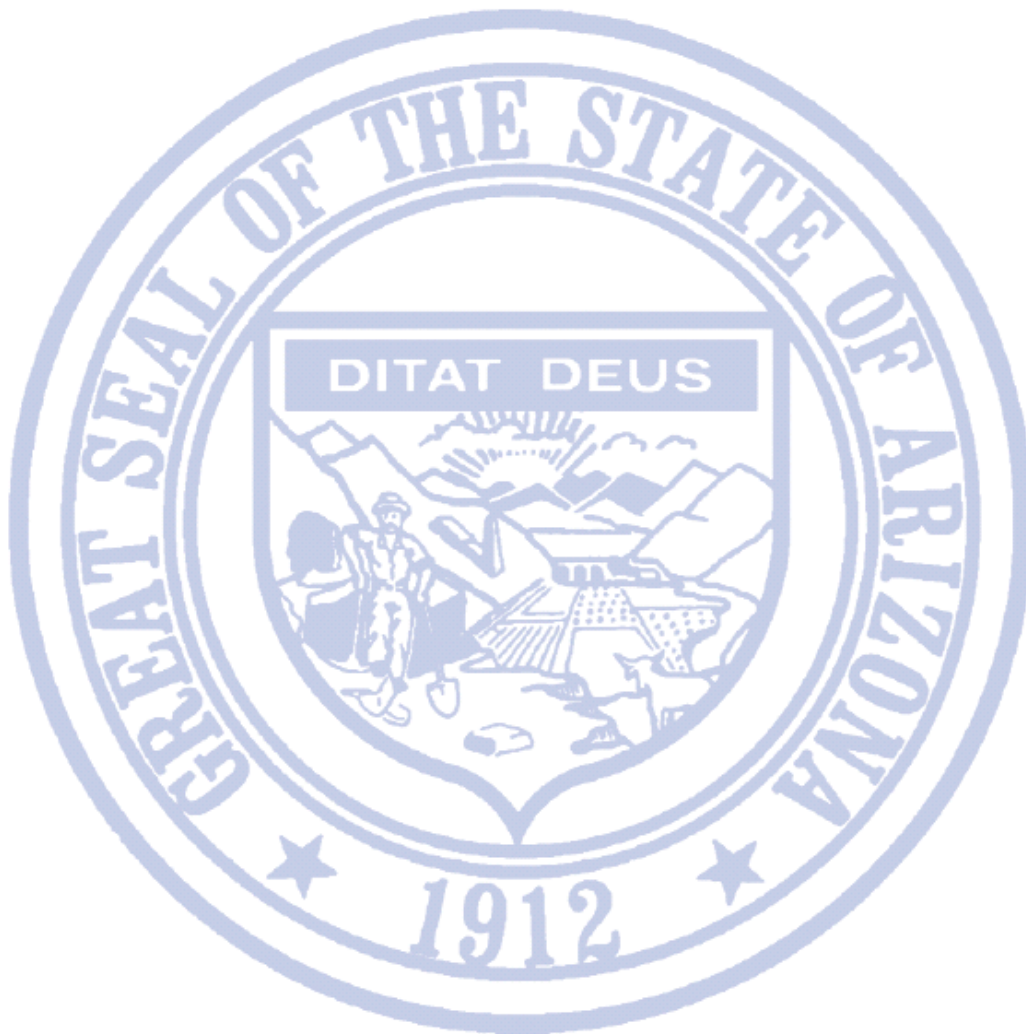


ARIZONA DEPARTMENT OF HEALTH SERVICES

Bureau of Tobacco and Chronic Disease



2012 BIENNIAL EVALUATION REPORT

Fiscal Years 2011 – 2012

ARIZONA DEPARTMENT OF HEALTH SERVICES

A REPORT ON TOBACCO CONTROL PROGRAMS AND SERVICES

BUREAU OF TOBACCO AND CHRONIC DISEASE



2012 BIENNIAL EVALUATION REPORT

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**THANKS AND APPRECIATION
FOR HER CONTRIBUTIONS ARE ALSO EXTENDED TO**

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EXECUTIVE SUMMARY

OVERVIEW

This report contains a description of tobacco related activities within the State of Arizona for Fiscal Years 2011 and 2012 (FY11 and FY12, respectively). The primary responsibility for its content rests on the Arizona Department of Health Services (ADHS) Bureau of Tobacco Chronic Disease (BTCD) with supplemental information from Smoke-Free Arizona and BTCD partners. Key outcome indicators for youth and adult tobacco-related behavior and attitudes are presented.

BIENNIAL EVALUATION REPORT HIGHLIGHTS: YOUTH

Prevalence of Youth Tobacco Use

Data shows a downward trend for tobacco use among all youth groups from 2000-2011. However, there is a dramatic increase in the use of hookah and smokeless tobacco, especially among high school students.

Youth Susceptibility to Initiating Smoking

Middle school student rates of current and lifetime tobacco use have dropped by 50 percent since 2000; however there was no significant change from 2009 to 2011. Current use of all tobacco products among high school students has shown a steep decrease for the first time since 2000, but an increasing number of students are using alternative tobacco products such as hookah.

Youth Access to Tobacco Products

From 2000-2011, the most common location reported by middle school students purchasing cigarettes was a smoke shop. The percentage of middle school students who were asked for proof of age when trying to purchase a tobacco product has decreased slightly; however being denied a sale due to age has slightly increased. An increasing number of high school students are purchasing their tobacco products at gas stations.

Youth Exposure to Secondhand Smoke

In 2011, the majority of Arizona's middle school students lived in homes with a complete smoking ban. Accordingly, the percentage of middle school students' self-reported exposure to secondhand smoke in a car or room is decreasing, for students living with a smoker. For students not living with a smoker, the percentage of exposure in a car or room has remained stable.

Youth Counter-Marketing

In 2010, the youth prevention marketing campaign, Venomocity: Brought to You by Addiction, shifted from a television and radio based campaign to target youth where they spend the majority of their time: online. Venomocity evolved and enhanced its social media efforts. Now housed exclusively online at Venomocity.com, additional social media components included a Facebook page and a YouTube channel.

2011 saw an increase in online efforts aimed at not only informing youth but engaging them as well. Three mini-campaigns encouraged youth to engage Venomocity online through social media outlets. 'Choose or Refuse' launched in May 2011 as a viral mini-campaign confronting the viewer with an invitation to use and providing ways to refuse tobacco. Three options to refuse are presented via Venomocity's YouTube channel. The viewer can select a different method each time thus creating different experiences. This draw was intended to bring youth back to the Venomocity online sites.

Launching in October 2011, 'AddictDEAD' was a four week mini-campaign housed on Venomocity's Facebook site. The mini-campaign featured four fictional people who died from tobacco related causes. A one minute teaser video on the 'AddictDEAD' feature person was shown. The 'dead' person then engaged the youth to ask questions in real time. This engagement format lead to increased activity on the Venomocity Facebook site.

The final mini-campaign launched in early 2012. The 'Versus' campaign pitted teens addictions against each other in online voting brackets. The winner was shown conquering the losing addition in a one minute long animated video. This campaign lasted two months with the final battle being that of the bracket winner and the ultimate addiction: tobacco.

BIENNIAL EVALUATION REPORT HIGHLIGHTS: ADULT

Prevalence of Adult Tobacco Use

Smoking prevalence in Arizona is now at 19.2 percent, which is just above the national average of 19.0 percent. 2010 BRFSS demographics indicated that current smokers are more likely to be male (20.1 percent) than female (17.3 percent). Employment is not shown to be a significant indicator of smoking, with 30.1 percent of smokers unemployed and 40.7 percent either employed for wages or self-employed, but more than one in five smokers (21.7 percent) make less than \$25,000 a year.

Adult Cessation: ASHLine

The Arizona Smokers' Helpline (ASHLine) launched a media campaign in 2010; previous to the campaign, the primary way that clients heard about ASHLine was through their healthcare providers. Post-campaign, call volume to the ASHLine drastically increased, posting a 327 percent increase in call volume, month for month, compared to the previous year.

IDENTIFYING AND ELIMINATING TOBACCO-RELATED DISPARITIES

In 2010 and 2011, BTCD continued working on the Community Health Initiative to Reduce Disparities (CHIRD), conducted community and health systems assessments with the end goal of increasing utilization of services among African American, American Indian, Asian-Pacific Islander, Hispanic (youth and families) and Lesbian, Gay, Bi-Sexual and Transgender communities, as well as migrant farm workers and formerly incarcerated persons.

REDUCING THE BURDEN OF CHRONIC DISEASE

In 2012, the Office of Chronic Disease developed The Arizona Chronic Disease Strategic Plan - a 3-year plan designed to address chronic disease prevention and control. The vision guiding this plan is: ***Arizona Communities Coming Together to Address Chronic Disease.***

To support this vision, the strategic plan was developed by Arizona stakeholders, both those who currently are and are not engaged in chronic disease prevention and control. To ensure the plan is not “top down” and driven by priorities identified by the state health department, community stakeholders were engaged in developing this strategic plan from the start. This plan was created through a community process and represents voices from across the state.

As community stakeholders came together, they identified the following expectations which they would like incorporated into the strategic plan:

- Provide efficient and effective strategies to address chronic disease.
- Leverage and coordinate efforts to address chronic disease throughout Arizona.
- Provide a framework to address chronic disease that is easy to understand.
- Offer a menu of strategies from which communities can choose how they would like to address chronic disease.
- Address health disparities.
- Develop a coordinated approach to addressing chronic disease rather than one that is focused on categorical diseases.
- Strengthen the capacity for communities to access health data and make data driven decisions to address chronic disease.

To accomplish these expectations, a framework was developed that provided goals, objectives, and matrices of evidence-based chronic disease policy, systems and environmental change strategies addressing chronic disease. This framework is presented by the areas of Where We Live, Learn, Work and Receive Care because community members felt these terms were easy to understand and can, therefore, be utilized by a wider audience. Additionally, since community stakeholders felt that a “one size fits all” approach to addressing chronic disease does not take into account the differing needs of Arizona’s many communities, a matrix¹ of strategies from which communities can choose how to address chronic disease was developed and is a part of this framework. Arizona’s state plan allows for communities to choose the specific strategies that best suit their community’s needs to address chronic disease.

This plan was designed to support other efforts in Arizona to address health improvement including the community health assessments and community health improvement plans that counties will be engaging in the near future if they choose to apply for public health accreditation. As other planning efforts such as this one are occurring simultaneously, community stakeholders felt that it is important to synchronize the chronic disease state plan with these other planning efforts and related initiatives. The Arizona Chronic Disease Strategic Plan and the framework that is presented within it are considered to be the beginning of a new coordinated process to address chronic disease in Arizona.

¹ Additional information about the matrices may be found in Section VII.

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INTRODUCTION

This report contains a description of tobacco related activities within the state of Arizona for Fiscal Years 2011 and 2012 (FY11 and FY12, respectively). The primary responsibility for its content rests on the Arizona Department of Health Services (ADHS) Bureau of Tobacco Chronic Disease (BTCD) with supplemental information from Smoke-Free Arizona and BTCD partners. Key outcome indicators for youth and adult tobacco-related behavior and attitudes are presented.

BACKGROUND

In 1994, Arizona voters passed the Tobacco Tax and Health Care Act (Proposition 200) which increased the state sales tax on tobacco products. Tax revenues are used to fund several programs: health care for the medically needy, medically indigent, and low income children; tobacco education and prevention; and tobacco-related research. This marked the beginning of Arizona's tobacco taxation, which was increased with the 2006 vote to raise the excise tobacco tax to \$2.00. Proposition 303, passed in 2002, voter protected the tobacco tax monies and these funds were required to be spent on tobacco prevention. Administered by ADHS BTCD, two percent of the tax was dedicated to a chronic disease fund.

In November 2006, Arizona voters approved the Smoke-Free Arizona Act, which took effect May 1, 2007. The act bans smoking in all indoor public buildings with the exception of retail tobacco stores, veteran and fraternal clubs, designated smoking hotel rooms, and outdoor patios. The ADHS Office of Environmental Health is responsible for monitoring compliance with the law.

In fiscal years 11-12 (FY11, FY12), BTCD focused on youth prevention, cessation activities and chronic disease services. Youth coalitions around the state rallied around a statewide coalition branded Students Taking a New Direction (STAND). Cessation activities centered around a media campaign that focused on assisting smokers in their quit attempts, which resulted in an increase number of calls by Arizona residents wanting to quit. Chronic disease services were provided by both statewide vendors and community vendors focusing on disparate populations. By focusing on these three areas, BTCD was able to make strides in creating a healthier Arizona.

CHRONIC DISEASE PARTNERSHIPS

When Arizona voters passed Proposition 303 in 2002, which increased the state tax on cigarettes by 60 cents per pack and taxed other tobacco products, two percent of this tax was set aside for a chronic disease fund which is administered by the ADHS BTCD.

Starting in FY09, ADHS BTCD funded nine community outreach programs and two statewide outreach programs for chronic disease prevention; however, these projects were phased out and replaced by services provided by county programs in FY10. Shown below are lists of the programs funded under this provision which continued through FY11 and FY12.

Community Outreach Vendors, FY11

- Asian Pacific Community in Action
- Black Hills Center for American Indian Health
- Campesinos Sin Fronteras
- Concilio
- Inter-Tribal Council of Arizona
- La Paz Regional Hospital
- Prescott Pride Center
- Tanner Corporation Development Community
- Worthy Institute

Community Outreach Vendors, FY12

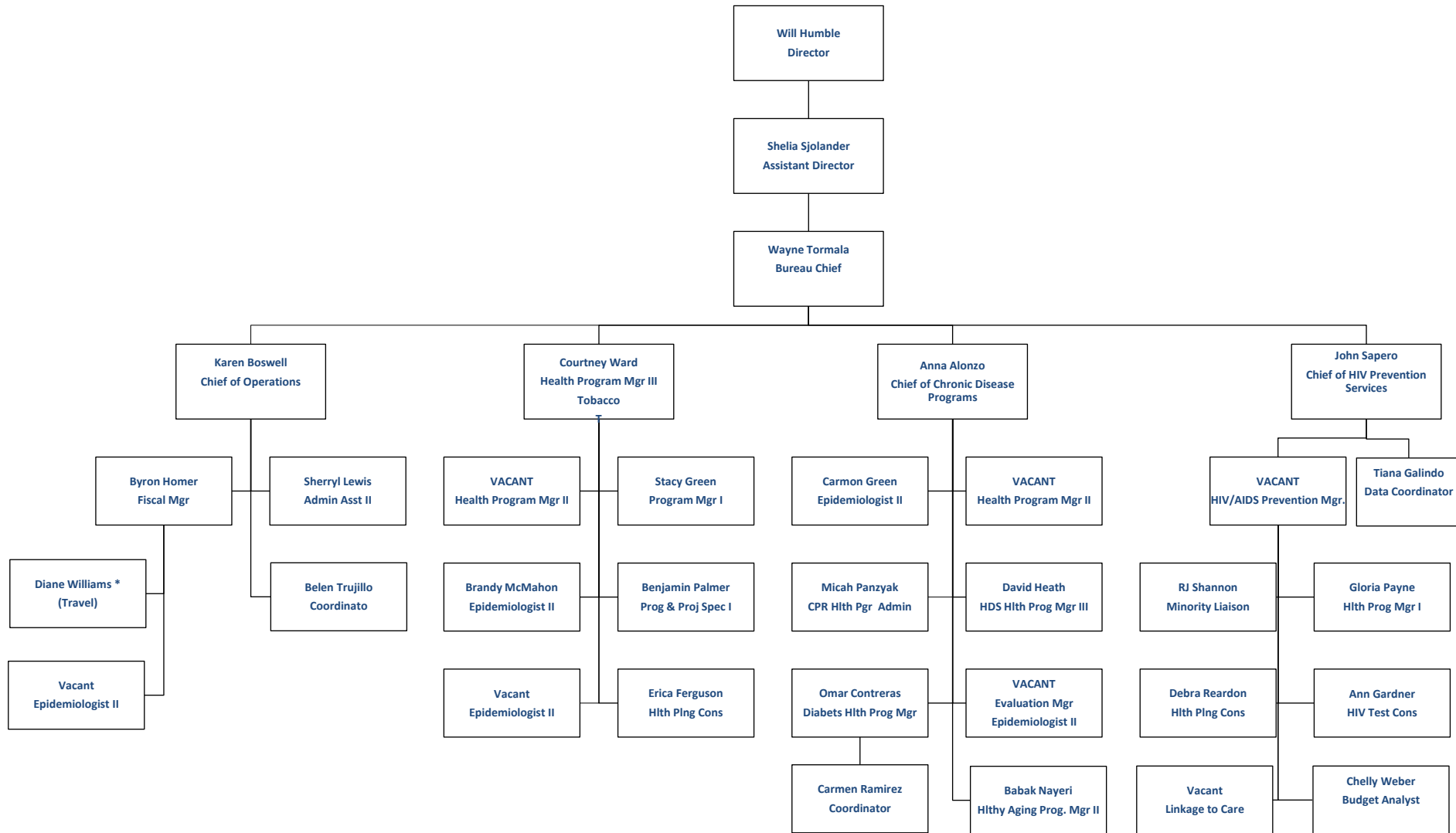
- Asian Pacific Community in Action
- Black Hills Center for American Indian Health
- Campesinos Sin Fronteras
- Concillio
- Inter-Tribal Council of Arizona
- La Paz Regional Hospital
- Prescott Pride Center
- Tanner Corporation Development Community
- Worthy Institute
- Maricopa County
- Pima Prevention Partnership
- Health Services Advisory Group

Statewide Projects Vendors, FY11

- AHCCCS
- Attorney General Office
- BeBetter Networks
- University of Arizona

Statewide Projects Vendors, FY12

- AHCCCS
- Attorney General Office
- BeBetter Networks
- University of Arizona
- HCE Quality Quest
- University of Arizona



ADHS BTCD – EXPENDITURES AND CONTRACTS

Following are the FY11 and FY12 Budgets for both of the tobacco Propositions (200 and 303), as well as federal monies.

ADHS Tobacco - Prop. 200

Table 1: PROP 200 expenditures and contracts for FY11-FY12

Projects	Expenditures	
	Fiscal Year 2011	Fiscal Year 2012
Local Partners		
Apache County	121,557	155,969
Cochise County	169,325	249,539
Coconino County	224,879	321,468
Gila County	127,953	125,380
Graham County	120,765	79,184
Greenlee County	58,368	69,136
La Paz County	50,193	179,318
Maricopa County	1,831,558	1,511,610
Mariposa Community Hlth Cntr	93,952	182,803
Mohave County	337,459	297,799
Navajo County	81,105	122,987
Pima County	1,145,792	859,606
Pinal County	342,150	303,773
Santa Cruz County	39,412	0
Yavapai County	258,507	201,669
Yuma County	236,220	222,648
Total Local Partners	5,239,195	4,882,889
Administrative	775,706	564,107
Community Outreach	338,277	275,725
Evaluation	280,435	42,835
Licensing – Empower	839,127	509,933
Marketing and Communication	2,780,961	5,244,804
Native American Outreach	437,931	410,602
Statewide Projects	3,909,970	3,814,331
Total Tobacco Expenditures	14,601,602	15,745,226

ADHS Chronic Disease - Prop. 303

Table 2: PROP 303 expenditures and contracts FY11-FY12

Projects	Expenditures	
	Fiscal Year 2011	Fiscal Year 2012
Local Partners		
Apache County	66,616	16,033
Cochise County	88,313	29,210
Coconino County	96,474	22,217
Colorectal Cancer Screening	117,558	512,897
Graham County	0	8,094
Greenlee County	0	5,463
La Paz County	0	8,346
Lung- COPD	503,265	532,802
Maricopa County	0	194,476
Mohave County	0	24,260
Navajo County	54,241	16,313
Pima County	0	72,133
Pinal County	0	11,755
Yavapai County	0	16,524
Yuma County	0	8,445
Total Local Partners	926,467	1,478,968
Administrative	254,014	403,089
Community Outreach	99,589	175,520
Evaluation	83,273	32,119
Marketing and Communication	16,977	214,248
Statewide Projects	139,698	27,148
Total Chronic Disease Expenditures	1,520,018	2,331,092

ADHS CDC – Federal

Table 3: CDC expenditures and contracts FY11-FY12

Projects	Expenditures	
	Fiscal Year 2011	Fiscal Year 2012
Administrative	832,364	873,995
Community Outreach	358,224	636,023
Evaluation	90,230	85,672
Marketing and Communication	582,375	125,503
Native American Outreach	230,484	155,097
Statewide Projects	186,738	135,695
Total Federal Expenditures	2,280,415	2,011,985

ADHS ARRA – Federal

Table 4: ARRA expenditures and contracts FY11-FY12

Projects	Expenditures	
	Fiscal Year 2011	Fiscal Year 2012
Administrative	126,962	123,889
Community Outreach	75,921	86,579
Marketing and Communication	224,794	20,491
Statewide Projects	318,993	423,889
Total Federal Expenditures	746,670	654,848

YOUTH PROGRAM ACTIVITIES AND SERVICES

This section contains data relevant to the outcomes of the Arizona tobacco control program. The data have been assembled to correspond with the outcome indicators for evaluating comprehensive tobacco control programs developed by the Centers for Disease Control and Prevention (CDC). Results for all identified CDC outcome indicators are not presented here. Rather, a selection of outcome measures with the highest relevance to Arizona tobacco control activities is provided. The behavioral and attitude-related results are reported separately for youth and adults.

For every outcome measure reported, the respective CDC indicator number and label are presented; this is to ensure consistency of reported results with CDC recommended and approved standard outcome measures.

PREVALENCE OF YOUTH TOBACCO USE²

CDC Outcome Indicator 1.14.1 Prevalence of tobacco use among young people

According to the Arizona Youth Tobacco Survey (YTS), 2011, 18 percent of middle school students reported ever using any tobacco product. This has decreased more than four percent from the 2009 YTS. The Youth Risk Behavioral Surveillance System (YRBSS) reported 46 percent of high school students had tried smoking, even one or two puffs. Additionally, 17 percent are currently using some form of tobacco. Cigarettes were the most popular tobacco product ever tried across both groups. (Refer to Figure 2 and Figure 3). Fewer than one in ten middle school students and one in five school students reported current use of any tobacco product.

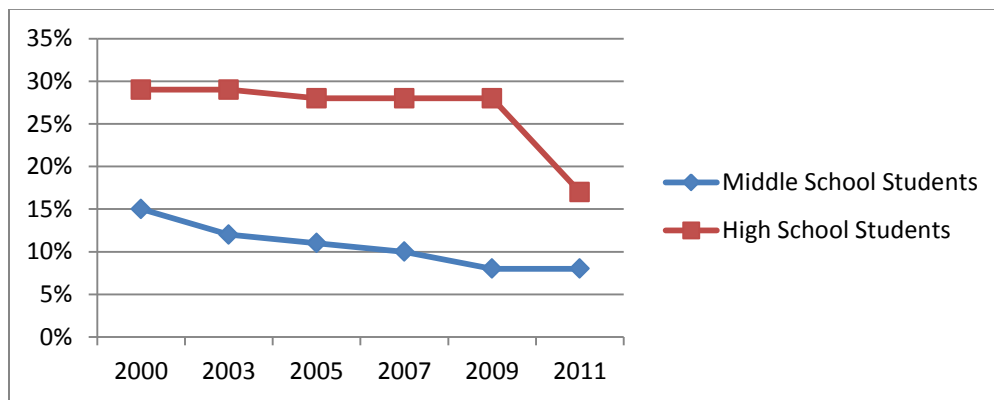


Figure 2: Trends in the use of any tobacco product by Arizona middle and high school students, 2000-2011

² In previous years, the AZ Youth Tobacco Survey (YTS) reported on both middle and high school populations; however, the high school portion of the survey was discontinued in FY 2008-2009. For the purposes of this report, the represented high school data was collected through the Youth Risk Behavioral Surveillance System (YRBSS).

It is also important to note that the data in these school-based surveys are representative of the public school student population; private schools, parochial schools, juvenile detention centers and other special schools are not included in the surveys. Existing evidence demonstrates that adolescents who are not in school (and those with high numbers of absences) have higher rates of tobacco use.

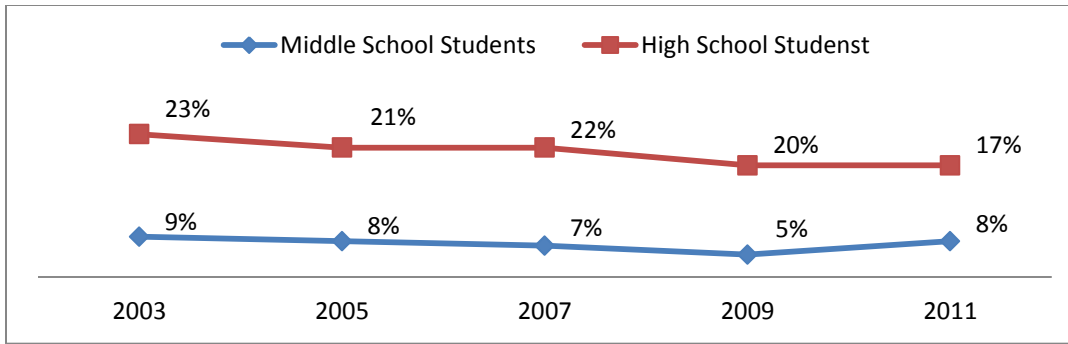


Figure 3: Trends in the use of cigarettes by Arizona middle and high school students, 2003-2011

White students reported the highest rates of *current tobacco use*, in both middle and high school. They also report the highest rates of *ever tobacco use* among middle school students. In 2011, Black/African American middle school students reported the lowest rates of *ever tobacco use*, whereas Hispanic/Latino and American Indian or Alaskan Native students showed the lowest rates for *current tobacco use* in middle school. Hispanic/Latino students showed the lowest rates for *current tobacco use* product in high school, as well as the lowest percentage of current cigarette smokers at 15 percent. Prevalence rates among students for *any tobacco products* and *cigarettes* are downward trending overall, however some populations are showing an increase. (See Figure 4.)

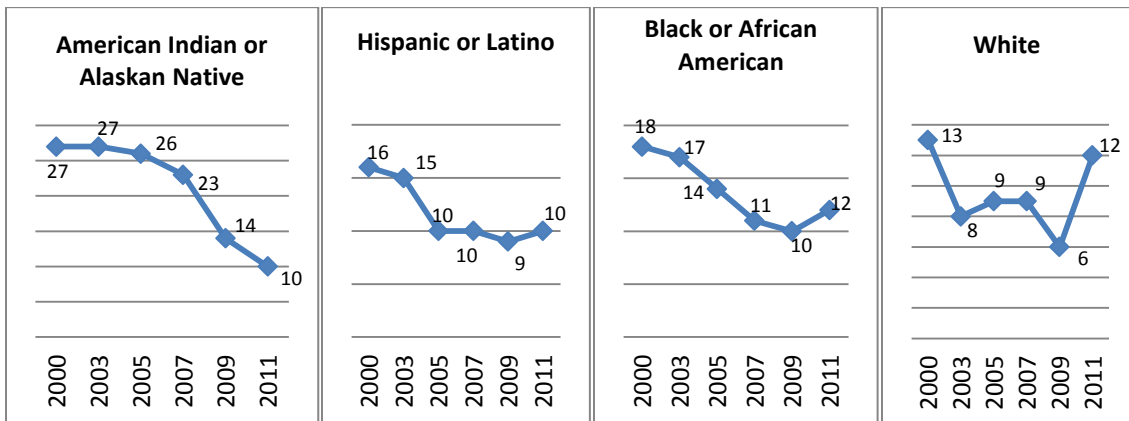


Figure 4: Percent any tobacco use among middle school students, by race, 2003-2011

Hookah use, contrary to the general downward trend of tobacco use among middle school students, has demonstrated marked popularity since 2005. This increase is much more dramatic for high school students. Whereas current use among middle school students in 2011 was measured at a little over four percent, it was almost four times that for high school, with more than one in four admitting to lifetime use. When broken down by grade, the increase in use among high school students is even more pronounced. (See Figure 5.) Of high school seniors, 53 percent admitted to ever using hookah.

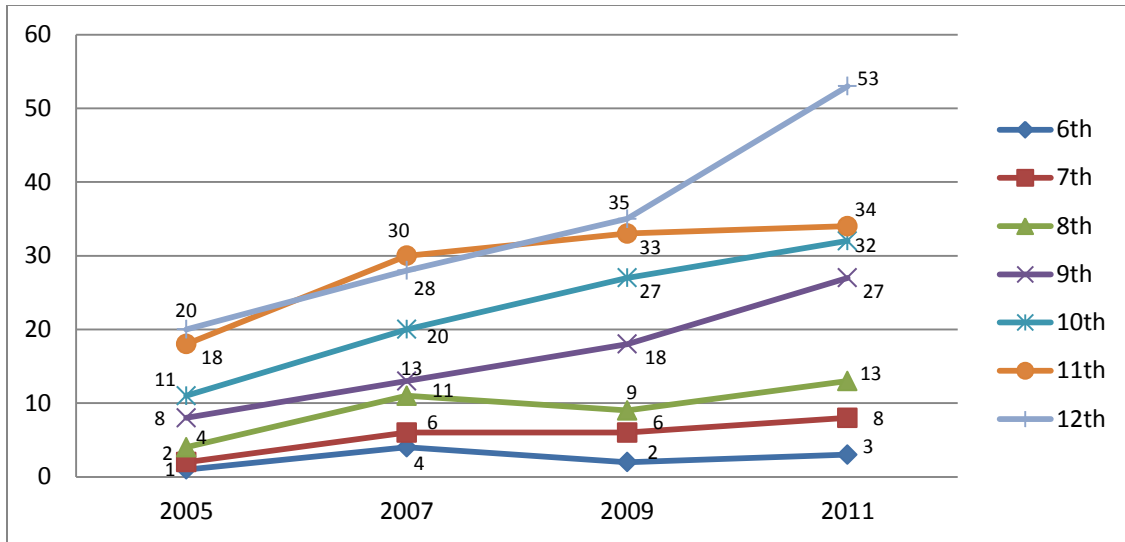


Figure 5: Percent ever use of hookah by middle and high school grades, 2005-2011

The Arizona Youth Survey (AYS), conducted biennially by the Arizona Criminal Justice Commission, shows a slight decrease in the popularity of smokeless tobacco since 2004. (See Figure 6.) The percentage of 8th graders who admitted to using smokeless tobacco—chew, snuff, plug, dipping tobacco or chewing tobacco—decreased, and is currently less than one percent more than the percentages of 8th graders who were current users in 2004. The number of current users in the 10th grade has also decreased, although it is still more than the percentage of current smokeless tobacco users in 2004. The percentage of 12th graders using smokeless tobacco has risen almost three percent since 2004.

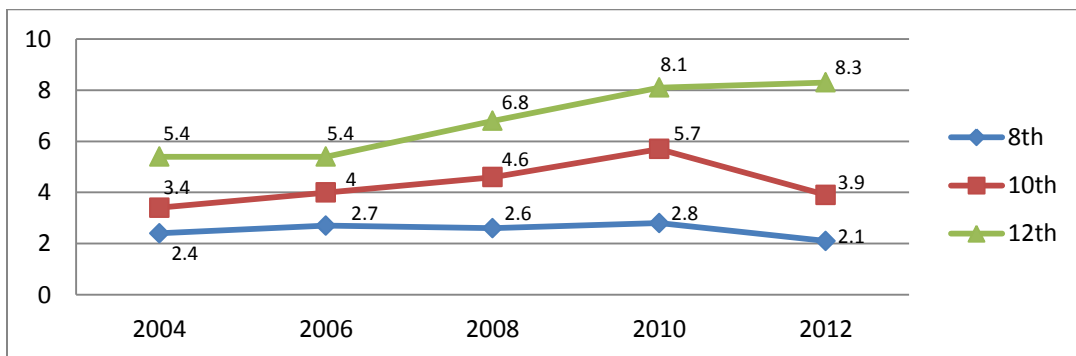


Figure 6: Current use of smokeless tobacco by middle and high school students, 2004-2012, by percent

PREVENTING YOUTH INITIATION

Susceptibility to Initiating Smoking

CDC Outcome Indicator 1.13.2 Prevalence of young people who report never having tried a cigarette

According to the YTS, three out of four middle school students reported having never used any tobacco product in 2011. Most middle school rates of tobacco use have dropped by 50 percent since 2000; when broken down by grade (6th-8th), 2011 showed any use by middle school students remained similar to 2009 numbers with a five percent drop in 8th grade exposure. (See Figure 7.)

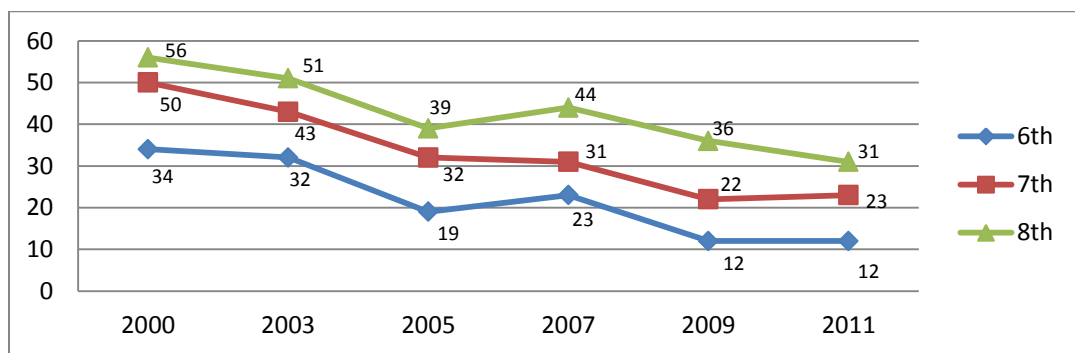


Figure 7: Trends in the use of tobacco products by Arizona middle school students, 2000-2011, by percent

Current use of any tobacco products among high school students has shown an overall decline by four percent in 2011. A decrease of more than five percent was seen in 9th, 10th and 11th grade students. However, current use of any tobacco products among seniors dropped less than one percent from 2009 to 2011. The use of cigars, cigarillos or little cigars decreased for 9th and 11th grade students by three to four percent but for 10th and 12th grade students it decreased less than one percent. Smokeless tobacco rates remained relatively steady (showing an increase or decrease of one percent or less) in 9th, 10th and 11th grade students but increasing in 12th grade students.

Access to Tobacco Products

CDC Outcome Indicator 1.11.2 Proportion of young people reporting that they have been sold tobacco products by a retailer

Students under 18 years of age often acquire tobacco products through social networks, borrowing or bumming cigarettes from friends. This is the largest identified way of acquiring tobacco products. Additionally, 30 percent indicated "Other" for the location of their purchases, but the other locations are not identified. The second highest identified way method of acquiring tobacco products was giving money to someone to purchase for the student.

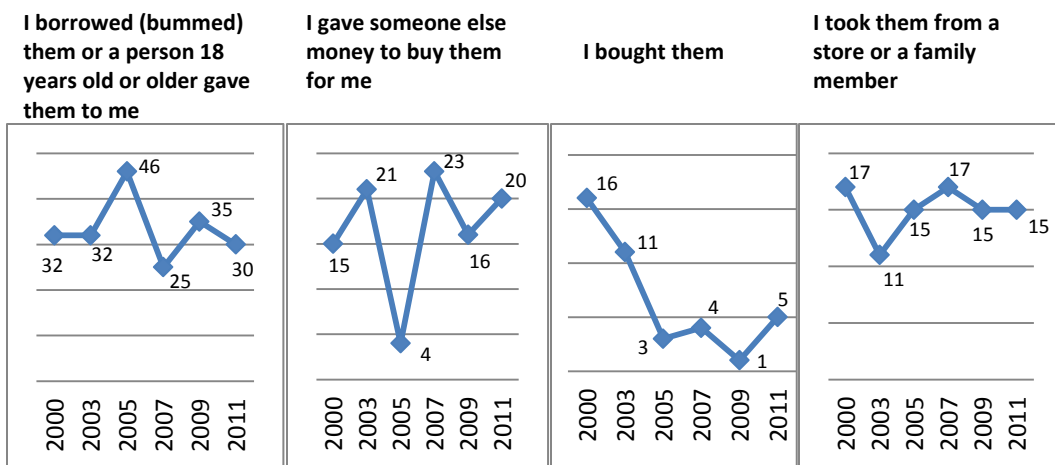


Figure 8: Self-reported access to cigarettes among middle school students, 2000-2011, by percent

Middle school students were asked where they last purchased the last pack of cigarettes they bought. Of the identified locations to purchase cigarettes, gas stations were identified as the most common location. Fewer students reported buying cigarettes from convenience stores, smoke shops and over the Internet (See Figure 9); however, questions regarding smoke shops and the Internet as purchasing sources were not asked every year.

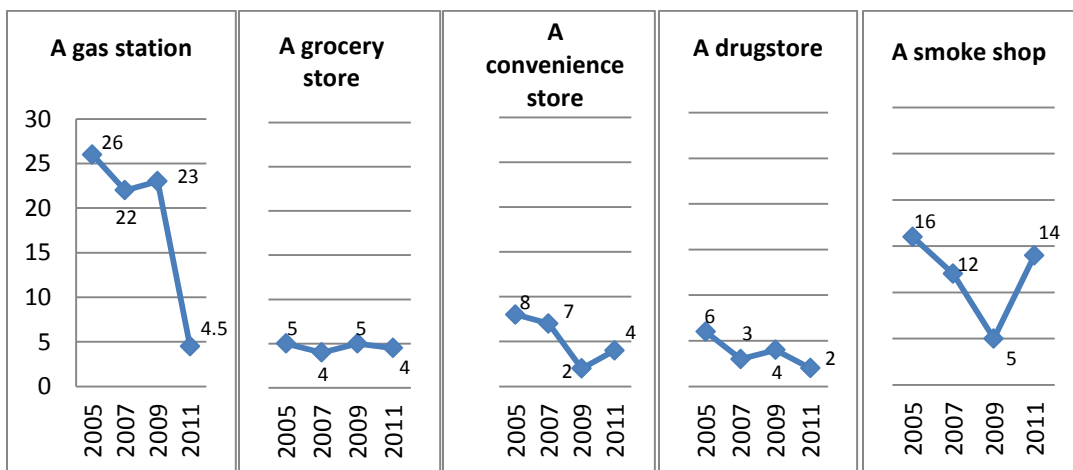


Figure 9: Store type where smokers in middle school bought their cigarettes, 2000-2011, by percent

The percentage of middle school students who were asked for proof of age when trying to purchase a tobacco product held a strong upward trend from 2000-2005, peaking at 30 percent. In 2007, however, the percentage of carded middle school students dropped seven percent. While the numbers from 2009 indicate a slight gain to 25 percent, the percentage has again dropped in 2011 to 19 percent. (See Figure 10.)

The percentages for sale refusals to middle school students show a similar pattern; following a 2003 high of nearly 40 percent, 2005 began an upward trend. In 2011, about one in three students indicated that they had been refused a tobacco purchase.

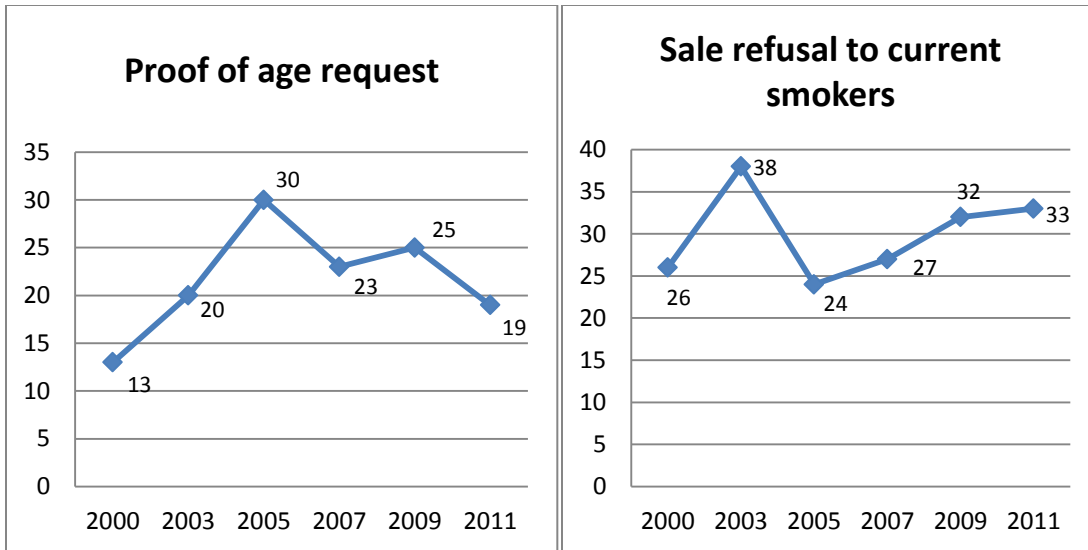


Figure 10: Self-report of middle school students who have been asked for proof of age and sale refusal, 2000-2011, by percent

Over time, fewer high school students have reported getting cigarettes through social means—from friends, for example—and more have reported buying them directly at retailers such as gas stations. This method of obtaining cigarettes has increased by more than 10 percent since 2009.

RESTRICTING YOUTH EXPOSURE TO TOBACCO

A.R.S. §13-3622, the “Youth Access Statute,” reads that

A person who knowingly sells, gives or furnished cigars, cigarettes or cigarette papers, smoking or chewing tobacco to a minor, and a minor who buys, or has in his possession or knowingly accepts or received from any person, cigars, cigarettes or cigarette papers, smoking or chewing tobacco of any kind, is guilty of a petty offense.

During FY11-12, BTCD was involved in several projects aimed at restricting youth access and exposure to tobacco products.

Youth Access to Tobacco Products (Counter Strike): Attorney General's Youth Tobacco Program

The Attorney General’s Office (AGO) monitors compliance with and enforces the tobacco Master Settlement Agreement (MSA) laws restricting the availability and sale of tobacco products to minors, and Arizona’s non-participating manufacturer legislation, A.R.S. §44-7101 and §44-7111. AGO also operates and maintains the Arizona Youth Tobacco Program: Counter Strike. The program seeks to:

- Reduce youth access to tobacco products
- Facilitate the efforts of local law enforcement agencies seeking to enforce Arizona’s youth tobacco laws
- Monitor the rate at which Arizona tobacco retailers comply with laws that prohibit the sale of tobacco to minors

The AGO systematically performs undercover investigations of tobacco retailers throughout the state. In order to assess compliance with the law, AGO agents and officers recruit, train and coordinate youth volunteers who visit tobacco retail outlets and attempt to buy tobacco products.

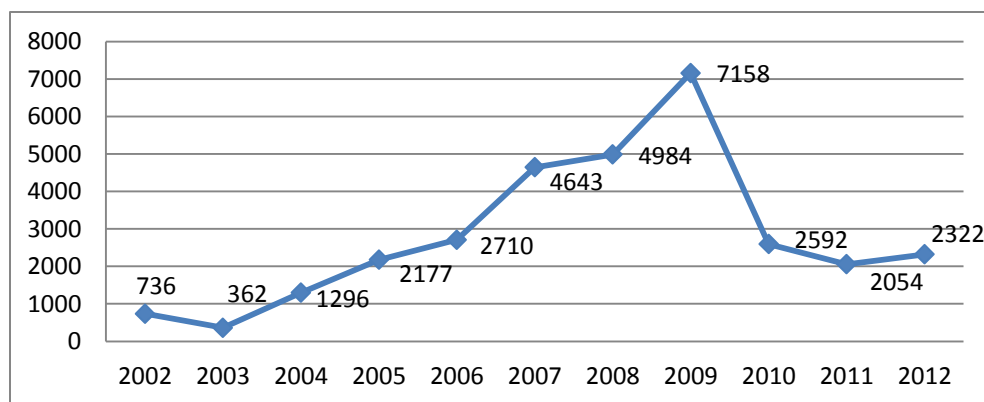


Figure 11: Total AGO inspections, 2002-2012

AGO conducts inspections, which are generally not announced, in every county in Arizona. Compliance data from these inspections is then shared with local law enforcement, who also

receive funding to conduct inspections within their communities, and ADHS. Since the program's inception in 2001, it has conducted over 30,000 inspections and issued over 2000 citations. Between 2003 and 2009, AGO had steadily increased the annual number of inspections, and from 2010 to the present that number has been declining. (See Figure 11.) This increase will naturally follow to the total number of failed inspections and citations. The percentage of failed inspections has been slowly trending downward. (See Figure 12). In 2009, the program measured its highest rate of compliance, with only 309 out of 1758 inspections failing (4.3 percent). While 2012 posted a significantly higher fail rate than FY09 (15.0 percent), it still represented a drop from 2006-2008, where the fail rate held steady around 19 percent.

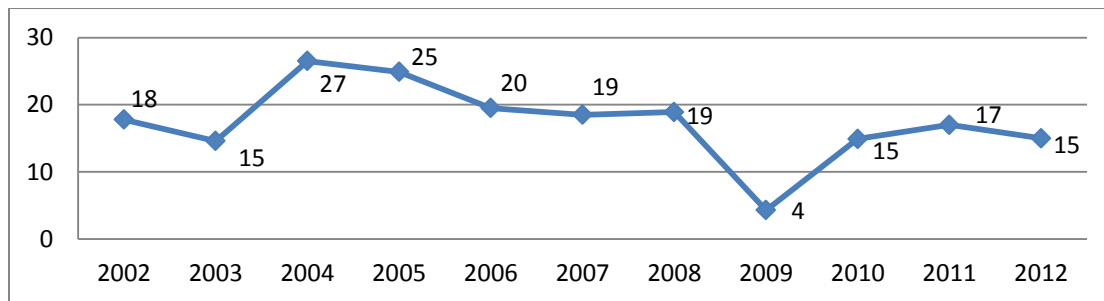


Figure 12: Percent of inspections that failed, 2002-2012

In contrast to the slow trend seen with failing inspections, the number of failed inspections that result in a citation has been steadily increasing. In its first year, citations were issued at 95.4 percent of failed inspections, followed by a steep drop in 2003 (to under two percent). Since 2003, citations have been steadily rising. There was a drop in 2011; however 2012 posted a citation rate of 65 percent (See Figure 13).

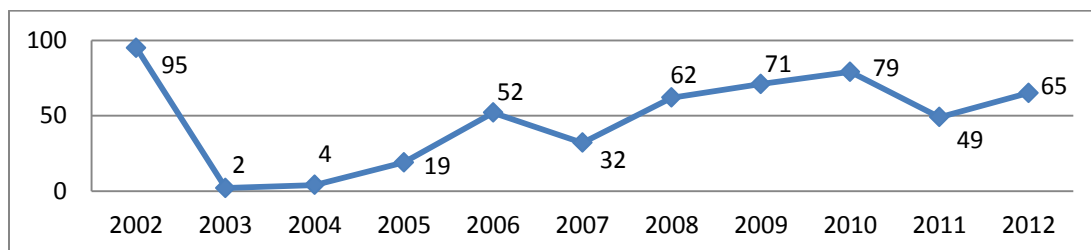


Figure 131: Percent of failed inspections that resulted in citations, 2002-2012

The Family Smoking Prevention and Tobacco Control Act, signed into law in June 2009, requires federal inspections of tobacco retailers, under the purview of the FDA, and enforces stricter penalties for noncompliance. Recently the AGO has begun issuing citations to both the clerk and the business. Unfortunately, the current way these are tracked are as one citation rather than two. The creation of a new database that tracks both types of citation is underway, and until then the current numbers fail to paint an accurate and detailed picture of the citations that are being issued.

Youth Exposure to Secondhand Smoke

Secondhand smoke contains cancer-causing chemicals and contributes to numerous diseases in both adults and children³. The impact of secondhand smoke on young people's health is heightened due to their ongoing physiological development. Young people are particularly vulnerable to exposure to secondhand smoke at home and in cars, where concentrations of toxic chemicals from tobacco smoke can reach excessively high levels.

Secondhand Smoke Exposure in Rooms and Cars

Figure 14 shows that among middle school students, self-reported exposure to second-hand smoke in a car or room at least once during the seven days prior to the survey has continued its downward trend in 2011. Overall, exposure in a room was still considerably higher than self-reported exposure in a car.

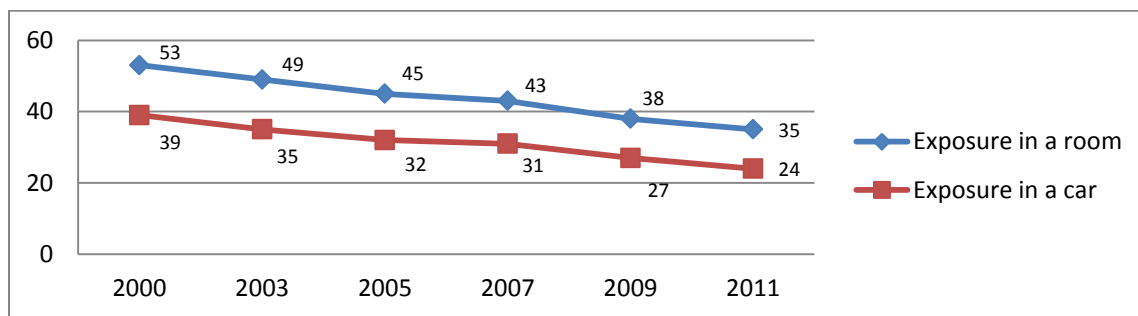


Figure 14: Percent self-reported exposure to second-hand smoke among middle school students during the past 7 days, 2000-2011

Figure 15 shows that among middle school students exposure rates declined for students living with a smoker and students not living with a smoker. However, strong differences emerged in the slope of the trend depending on the absence or presence of a smoker in the home. That is, reported exposure of students living with a smoker decreased much more than exposure reported by students not living with a smoker. This was true for both rooms and cars. Among those living with a smoker, rates have dropped by about seven percent for both rooms and cars since 2009. In contrast, those not living with a smoker showed no significant change over the same period.

³ U.S. Department of Health and Human Services (2006). The health consequences of involuntary exposure to tobacco smoke: a report of the Surgeon General U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

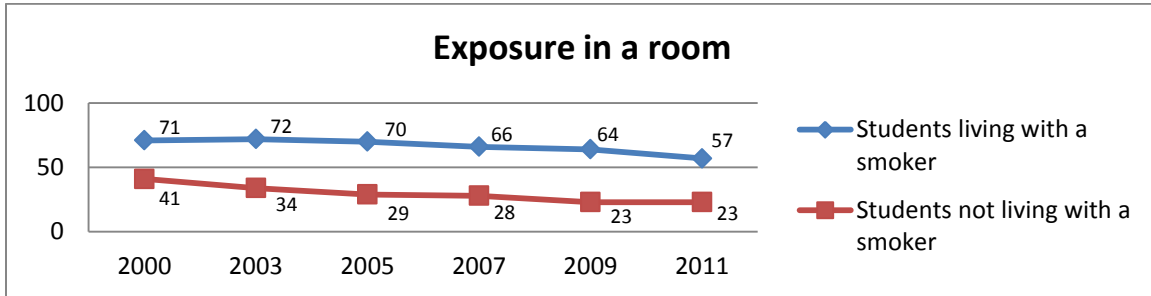
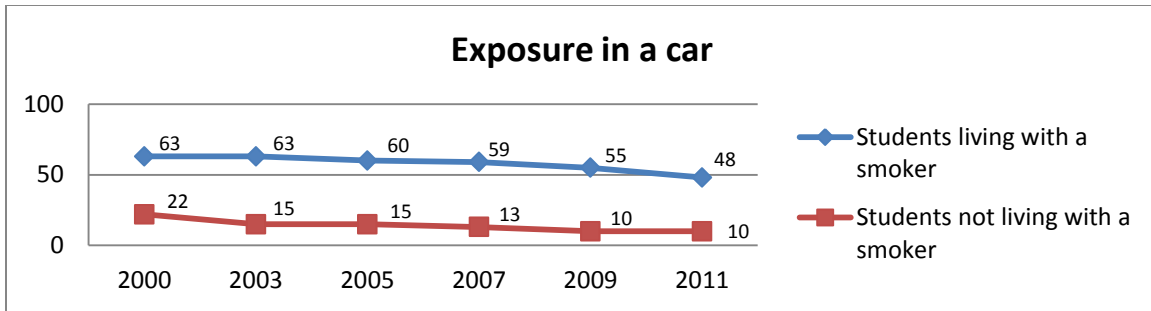


Figure 15: Percent self-reported exposure to second-hand smoke among middle school students, by presence of smoker in household, 2000-2011

Rules about Smoking in the Home

Figure 16 shows that middle school students reported steady increases in complete smoking bans at their homes, with a complementary decrease in partial bans and homes with no bans. The vast majority of middle school students now live in homes with a complete smoking ban.

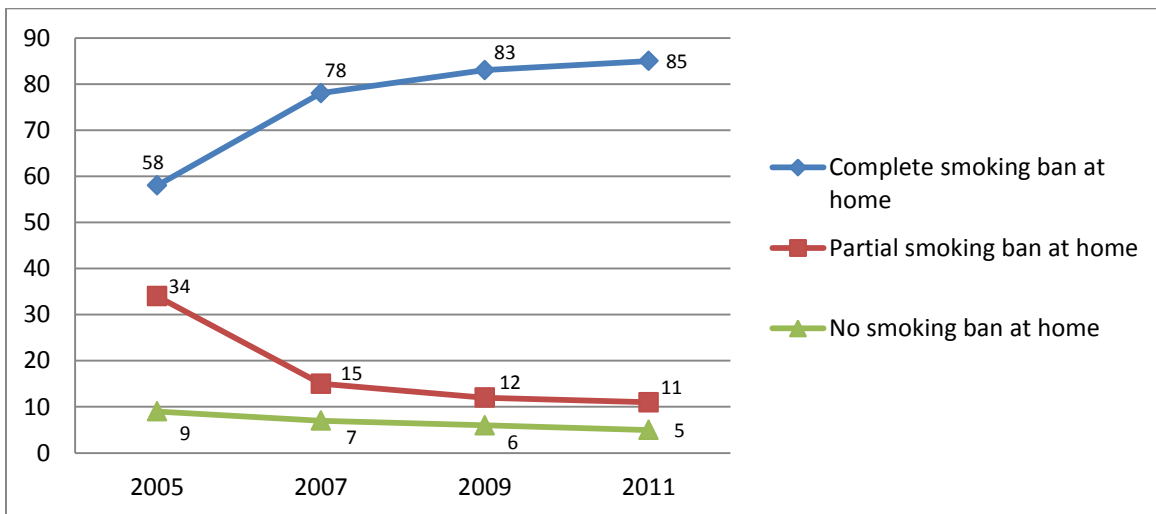


Figure 16: Smoking ban at home, 2005-2011, by percent

Overall, students living with a smoker were much more likely to report a partial or complete no smoking ban at their home than those not living with a smoker. (Refer to Figure 17.). However, those living with a smoker were much more likely to report a complete ban in 2011 than in 2005. The rate of complete bans at homes with smokers has almost doubled, whereas reported rates of no ban in those homes has slightly dropped. Among those not living with a smoker,

nearly all students reported a complete smoking ban at their home, up from roughly three out of four students in 2005.

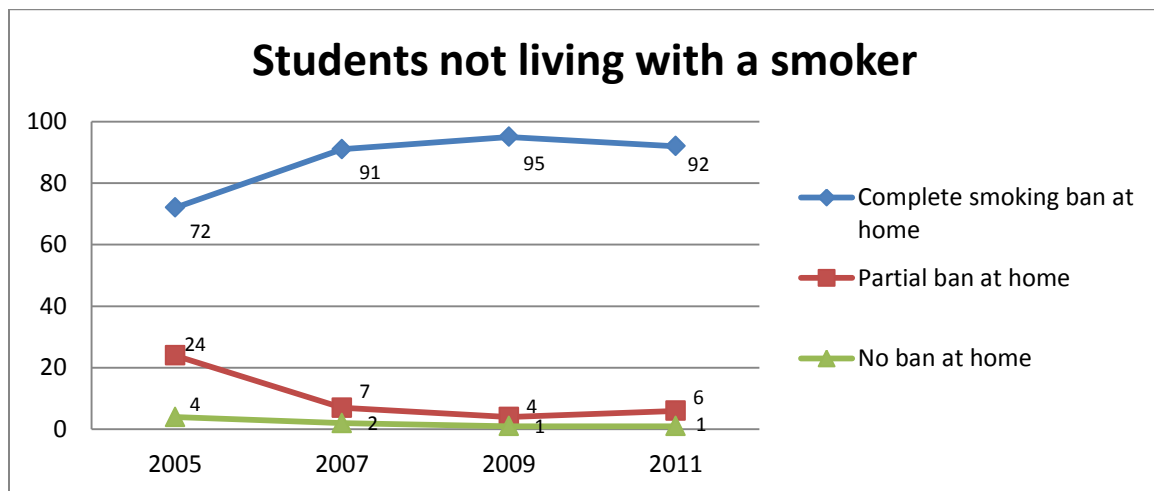
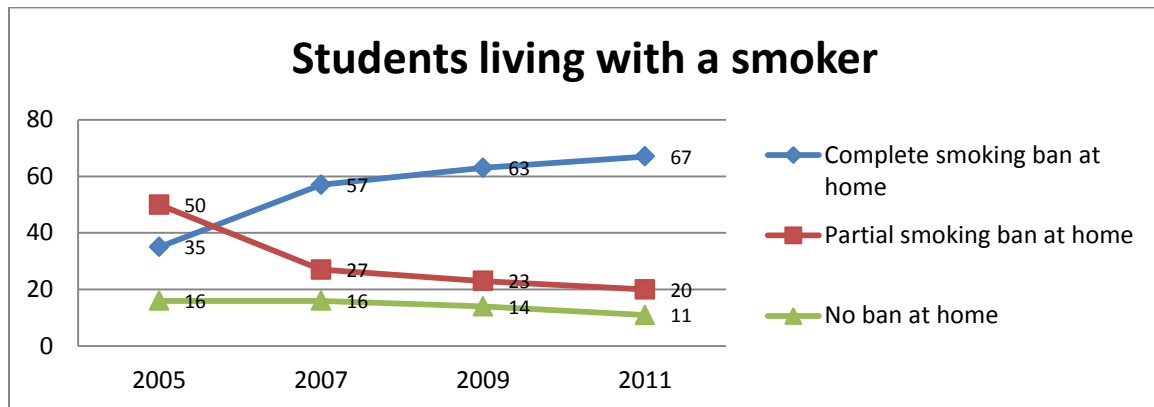


Figure 17: Percent of smoking ban at home, by presence of a smoker, 2005-2011

YOUTH COUNTER-MARKETING

State tobacco control programs often lack the flexibility and authority to directly influence or advance tobacco policies that change social norms within a community. Thus, tobacco control programs cannot be considered truly comprehensive unless there are coalitions in place to actively advocate for policy change and foster a message of awareness around the issue of tobacco control (See CDC, *2007 Best Practices for Comprehensive Tobacco Control Programs*).

Youth play an intricate and unique role in advocating for tobacco control policy change because the age of initiation is lower—12 years old in Arizona—than the legal age to purchase tobacco products. Tobacco companies know that since adults report 19 as the average age for becoming a regular smoker, the 12-17 year-old target age group is extremely important. It is also extremely impressionable, and tobacco companies use specific marketing tactics to target this demographic.

From the release of the 1964 Surgeon General's report through the early 1990s, health education was primarily focused upon youth tobacco control intervention, based on the assumption that young people simply needed the right information to make the right choices. Interventions consisted of adults talking "at" youth, usually within a classroom setting and using scare tactics to demonstrate the negative health effects of tobacco. However, in the early 1990s, programs begin to notice that youth were not primarily influenced by statistics, but rather by their social environment—their peers, their family and the media. It was now seen as imperative that youth become more directly involved in addressing tobacco control policies, instead of being indirectly involved through health education; they are important strengtheners in developing future tobacco control policy.

BTCD has set out to implement a counter-marketing campaign aimed at youth, to increase their knowledge and reduce the initiation of tobacco use. This campaign utilizes both traditional means (e.g., television, radio) and innovative media favored by youth (e.g., text messaging, music and social networking sites like Facebook, MySpace and Twitter). Additionally, an integral part of this campaign is the incorporation of grassroots outreach, to engage and empower youth to directly attack the manipulative efforts of tobacco companies, as well as to

- improve policies around tobacco control
- change social norms
- reduce smoking consumption and the age of initiation in Arizona

This grassroots outreach will be achieved through a comprehensive statewide network of community youth coalitions, which will work within their own communities to counter-market anti-tobacco messages to youth in and out of school, making tobacco less desirable, acceptable and accessible. This strategy coupled with targeted marketing tactics will engage and empower youth to directly attack the manipulative efforts of tobacco companies, improve policies related to tobacco control, and change social norms that reduce smoking consumption and age of initiation within the State of Arizona.

Background: The Social Normative of Tobacco

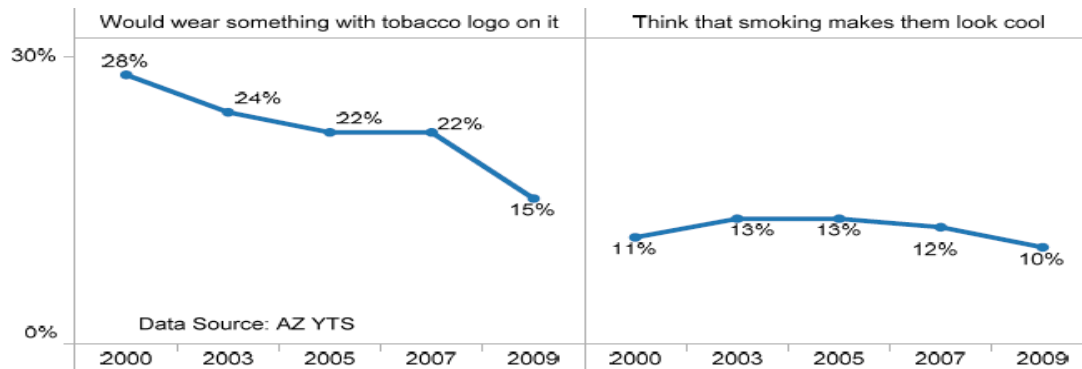


Figure 18: Arizona middle school students who would wear something with a tobacco logo on it (left) or think that smoking makes them cool (right), 2000-2009

CDC Outcome Indicator 1.6.2. Level of receptivity to anti-tobacco media messages

The AZ YTS asks middle school students whether they think smoking makes them look cool. This measure has historically been low, and its trend over the past decade has been stable (moving from 11 percent in 2000 to 10 percent in 2009).

The YTS also asks middle school students if they would wear something with a tobacco logo on it, and the trend here has been more significant. In 2000, 28 percent of students agreed that they would wear a tobacco logo; in 2009, this number was 15 percent, represented a roughly 50 percent decrease. (See Figure 18.)

The percentage of middle schools students whose parents talk to them about the dangers of smoking has remained stable since 2000, measuring 73 percent in 2009 (from 71 percent in 2000, and a peak of 75 percent in 2005).

Venomocity: Brought to you by Addiction

In 2007, BTCD embarked on a statewide strategic planning process to address rising smoking prevalence rate among youth, 12-17 years old. It was determined the Bureau needed to raise awareness about tobacco among teens and to develop advertising to prevent youth from starting to smoke, reversing the trend of high youth prevalence and low age of initiation.

BTCD formed focus groups and conducted input sessions targeting this age group; the "IK Council," or "I Know Council," evolved from these meetings. In an effort to incorporate youth into the policy process, this group of 12-17 year-olds then worked with BTCD to develop an effective youth campaign.

The formative research with the target audience was telling. While the 12-17 year-olds reported knowing the negative health effects of smoking, and even described smokers as "gross, hairy-tongued and stupid," they still did not see that smoking today as teens would lead them into becoming "a smoker" later in life. Almost 90 percent of present-day adult smokers report starting in their teens, and two out of three teens that start younger will still be smoking when they are 19 years old. While youth understood the harmful health effects of tobacco and all the "gross" factors, they did not "see" tobacco's addictive qualities.

Using input from these focus groups, it was determined that this campaign was an opportunity to focus on addiction; by providing addiction with an identity, giving it dimensions and making it real, youth can better understand how it grows inside of them and takes control after just a few cigarettes.

Program Goals and Development

BTCD worked with the IK Council, to help teens guide the creative process toward what they considered realistic and "not cheesy." The IK Council helped create storyboards for the television and radio advertisements, Internet banner ads, social media elements such as Facebook and MySpace pages and the entire website "lair" at venomocity.com. Working in tandem with the youth, the creative team developed an identity for addiction. "Venomocity" evolved as the personality of addiction. Addiction became an entity that is never fully seen—appendages and flashes of imagery are visible, but never the whole "beast."

Addiction/Venomocity wants you to smoke. It is a smooth talker, here to take control; it lurks within you when you take even the first puff of a cigarette. It has a lair—venomocity.com—which it invites kids to visit. On the website, youth can

- play tobacco themed games
- explore the "Hall of Fumes" to see tobacco addiction's greatest achievements throughout history
- play with an electro larynx to hear what the voice of a person who has lost their voice box to smoking sounds like.

Three commercials were also developed to suggest that addiction, through tobacco use, could take over after just a few cigarettes.

- "First Time" tells the story of a young girl trying her first cigarette, which she does not like, but is forced to resume smoking when the appendage of addiction pushes it back into her mouth.
- "Cravings" illustrates a young man fighting the desire to have a cigarette and the force of addiction driving him to smoke, with the appendage of addiction dragging him down a hallway to a lit cigarette.
- "Surrender" illustrates the control addiction has over a young man who is awakened from sleep by the appendage of addiction and forced to go outside for a cigarette.

Two additional commercials were also developed to highlight tobaccos negative effects once consumed.

- "Feeding time" illustrates how tobacco ravages the insides of the smoker.
- "Getting Owned" tells the story of a young girl watching a nature program on parasites only to reveal how she is in fact a host of the parasitic effects of tobacco use.

The commercials were placed in targeted media—cable and broadcast television shows with an audience more than 50 percent 12-17 years old. They were also placed in theaters statewide, 10 minutes prior to PG-13 and R- rated movies. The commercials, and all media elements, have the call-to-action to visit www.venomocity.com.

Beginning in the fall of 2010 focus on developing social media sites to support Venomocity.com began. Through continued efforts of the IK Council it was determined that the preferred medium of choice was FaceBook. Initial efforts included posts in the voice of ‘Addiction’ aimed at encouraging discussion among the youth. Three mini-campaigns were launched to increase visibility and interaction.

Choose or Refuse

The ‘Choose or Refuse’ mini-campaign was intended to be a viral campaign launched exclusively on YouTube.com and housed on the Venomocity.com site through a webportal. Launched in May 2011, seven video shorts were produced utilizing local Arizona youth. Each video began with setup of asking either one or more youth if they wanted to try tobacco. Three video options were provided in which the viewer could then select different ways in which the teens could say no.

AddictDEAD

AddictDEAD launched in October 2011 to coincide with Halloween. Four fictional ‘dead’ tobacco users were profiled. Their story was portrayed in a 60-second intro. Launched in consecutive weeks, each story allowed for youth to ask the ‘dead’ tobacco user questions.

- “Mark” told the life story of an older man who died from lung cancer.
- “Debrah” told the story of a 9 year old girl who died in a house fire started by a cigarette
- “Addison” told the story of an ambitious woman who died of smoking related causes even though she was on a casual/social smoker.
- “Dean” tells the story of a baseball player who died due to cancer caused by spit tobacco.

Addiction vs Addiction

Launched in early 2012, the campaign pitted addictions (e.g. video games, frozen yogurt, vampires) against each other through a tournament bracket. A teaser video highlighted the upcoming battle and asked youth to vote on the winner. Once a winner was selected, the animated battle took place propelling the winner further into the competition. The winning addiction battled tobacco addiction as the final battle to coincide with World No Tobacco Day on May 31st, 2012.

All three mini-campaigns attributed to an increase in the number of ‘likes’ that the [Venomocity](http://Venomocity.com) FaceBook received. At the conclusion of the campaign the number of likes was just over 22,000.

Outreach

[Venomocity: Brought to You by Addiction](http://Venomocity.com) was created with peer input. Outreach events were held statewide to promote Venomocity.com as well as receive feedback on revisions and updates to the website from teens in the targeted demographic. Events were held at youth dominated events such as music concerts, fairs, teen holiday gatherings and at school related events. Over 12,000 individual teens signed up to receive regular updates from

Venomocity.com. Feedback received helped guide the direction of the content produced as well as help evaluate its success.

Venomocity Evaluation

The primary goal of *Venomocity: Brought to You by Addiction* is to increase awareness of addiction among youth. Campaign evaluation focused upon

- assessment of reach and frequency numbers
- analytics from Internet engagement, such as the number of visitors to venomocity.com
- an assessment of community/grassroots event engagement
- qualitative assessment by the IK Council
- eight focus groups with the target audience, which were conducted six months into the campaign
- an Internet-based survey emailed directly to the target audience, conducted at nine months

According to the measures, the program exceeded its initial goals. The focus groups and Internet survey indicated that the message is received and well understood by teens. “The ads made me think that after you smoke for the first time you can’t stop. It made me feel surprised,” was one focus group quote. Another teen said, “It scared me. It’s creepy to see how much hold your body/brain (even addiction) can have over you. The addiction or whatever the black thing was, it was a symbol of how controlling it is.”

Seventy percent of participants reported they had seen or heard the advertising on television, in a theater or on the Internet; the most common medium was television (80 percent); 76 percent of respondents also indicated that these commercials were “better” than other anti-drug commercials. Venomocity.com measured more than 350,000 page views; the average visitor stayed on the site close to six minutes, indicating that visitors were engaged with the site. Through statewide community events, including those held in both rural and urban areas, close to 10,000 youth email addresses were collected; this also addresses engagement as youth interact with Venomocity at an event, and then receive emails informing them of new features on venomocity.com and additional events happening near them.

The majority of respondents agreed or strongly agreed that the campaign helped them understand the harmful effects of tobacco (77 percent); helped them understand that tobacco is addictive (89 percent); and made them less likely to try tobacco (79 percent).

Youth Coalitions

In addition to the *Venomocity: Brought to You by Addiction* campaign, BTCD is working to develop a statewide network of local youth coalitions by FY12, to directly involve youth in changing both the social norms surrounding smoking and current tobacco policy. To achieve this goal, the following objectives will be implemented:

- Review best practices and establish a Youth Coalition Development Plan
- Engage qualified partners to assist BTCD in engaging youth in development and extension of the Plan
- Engage youth statewide in local and statewide coalition activities for tobacco use prevention

- Create a youth coalition leadership council and youth communication hub at the statewide level that establishes the youth-led coalition efforts
- Provide on-going technical assistance and training on leadership, including peer-to-peer leadership, advocacy and community education.

Coalitions are one of the most cost-effective and efficient strategies for achieving social norm change; they also provide a healthy learning environment for youth to obtain skills in leadership and engage peer-to-peer communication.

Students Taking a New Direction (STAND)

Efforts to build a sustainable network of youth coalitions are ongoing. At the end of FY12, BTCD awarded Pima Prevention Partnership (PPP) with a contract to serve in assisting BTCD funded partners on developing youth coalition structure and retaining youth participants. In FY12, the *Join the Movement* statewide youth coalition effort was branded as Students Taking a New Direction or STAND.

BTCD in conjunction with contractor Pima Prevention Partnership (PPP) and its subcontractors Arizona Youth Partnership (AzYP) and Amistades continue to bolster youth coalition efforts statewide. Through adult and youth trainings, an annual celebratory conference and an increased online presence via STAND Facebook and www.Standaz.com ; the statewide and local initiatives are thriving in year three. Local coalitions retain their identity but on a statewide level youth coalition activities are unified via STAND.

Trainings

PPP has held trainings for adult coalition leaders as well as youth coalition members. Trainings have been held regionally during both the fall and spring in Phoenix, Flagstaff and Tucson. Adult coalition leaders learn how to effectively foster youth coalition development, assist the coalition members where needed and provide additional logistical support. Individual technical assistance is provided where needed throughout the fiscal year to both youth members and adult coalition members by PPP. Trainings for the youth include education on advocacy, public speaking, social media and message development. A winter summit is in the works to bring together youth to start planning for the end of the year youth tobacco coalition conference.

Youth Prevention Network

Youth prevention has been broadened to include not only youth coalition activities but also to incorporate prevention outreach, point-of-sale (POS) efforts including the Attorney General's sting operations and the FDA program. The centralized hub of activity will be StandAZ.com. Information and resources will be provided for youth, adult leaders and will house but not be limited to the aforementioned initiatives. FaceBook and YouTube sites have been created to tap into the social media opportunity that presents itself when working with youth. Continued engagement and involvement with the youth help with recruitment, execution and promotion of statewide and local youth coalition efforts.

YOUTH CESSATION: HELPING TOBACCO USERS QUIT

CDC Outcome Indicator 3.11.2. Proportion of young smokers who have made a quit attempt

In 2011, roughly half of all current cigarette smokers in high school reported attempting to quit in the past twelve months. Additionally, slightly over 50 percent of middle school students reported a quit attempt. (See Figure 19.)

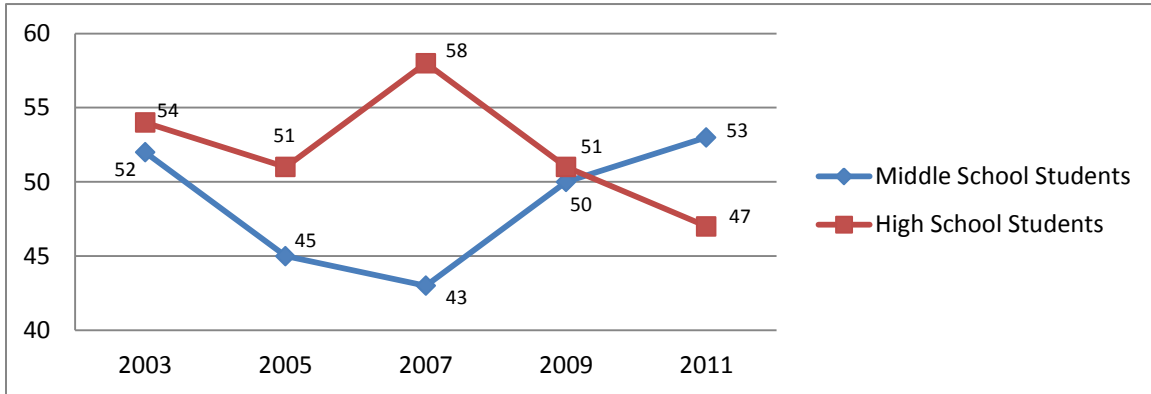


Figure 19: Percent self-reported quit attempts among current smokers in middle school and high school, 2003-2011

ADULT PROGRAMS ACTIVITIES AND SERVICES

CHANGES TO THE BEHAVIORAL RISK FACTOR SURVEILLANCE SURVEY

The Behavioral Risk Factor Surveillance System (BRFSS) is a statewide health survey developed by the Centers for Disease Control and Prevention (CDC) and conducted by individual states and U.S. territories. The Bureau of Tobacco and Chronic Disease utilizes this tool to measure state prevalence for tobacco use amongst Arizona's adult population. Two key changes were made for the 2011 BRFSS to both enhance and improve this survey. These two methodological changes were the inclusion of cell phones in the survey and a change in the weighting method. These were done to obtain a more accurate assessment and obtain a more representative sample of the total population.

The use of cell phones has increased in recent years and as much as 30 percent of households have only cell phones, as opposed to a landline/cell phone combination or solely landline connection. Historically, BRFSS had only administered surveys to households who had landline telephones. Landline telephones are on the decline so it is essential to change survey collection methodologies to adjust with the trend.

Statistical weighting of data is an important factor of any survey. In addition to administering the survey to cell phone users, the CDC has also changed the way it weights data from post-stratification to iterative proportional fitting (also known as raking). Raking allows for more variables to be taken into consideration when weighting, which gives a more meaningful weight to the data and reduces the potential for bias. For example, if half of our population is female but for some reason our survey respondents were 75% male, and the majority of all respondents were over the age of 50, the prevalence of gestational diabetes would be skewed. However, with raking we can assign weights to the people we reach. In this case, the raking could include gender, age, and even status of health insurance. By weighting the responses differently, the data will come closer to revealing the true percentage. BRFSS raking does this with multiple categories, including telephone source, race and ethnicity, regions within states, education level, marital status, age, gender, and renter/owner status. This method gives us a more representative estimate of health risks and behaviors.

In addition to numbers alone, the majority of "cell phone only" households are comprised of young adults who do not own their own homes, are generally unmarried and are predominantly self-identified as Hispanic. By including the use of cell phones in the BRFSS, the data now allows us to have a more representative sample from populations that have a higher risk for certain diseases, as well as a more thorough assessment of the population as a whole. While it is clear that these changes have improved the information available, comparisons with prior surveys are not easy. The inclusion of cell phones dramatically changes the population that is reached in the survey. The change in weighting makes comparisons difficult as well, due to the fact that the type of phone (landline or cell phone) is part of the new weight. As this wasn't part of the weight in years past, they cannot be easily compared. However, the ability to make a more accurate assessment of our state's health is something we can appreciate as we move forward with a clearer understanding of our community.

PREVALENCE OF ADULT TOBACCO USE

CDC Outcome Indicator 3.14.1 Smoking Prevalence

According to the 2011 Arizona Behavioral Risk Factor Surveillance Survey (BRFSS), 19.2 percent of respondents identified themselves as current smokers. Figure 20 retrospectively weights the data from previous year's surveys to show what the prevalence would have been with the current weighting system. Table 5 lists demographic information about respondents who reported they are current smokers.

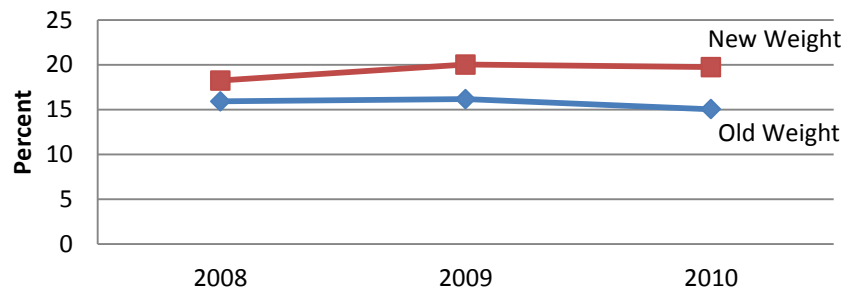


Figure 20: 2008-2010 BRFSS, Prevalence of tobacco use, retrospectively weighted

Sex			
Female	17.3	Male	20.1
Age		Employment	
18 – 24	19.0	Employed for Wages	20.0
25 – 34	24.7	Self-employed	20.7
35 – 44	18.3	Out of work	30.1
45 – 54	21.0	Homemaker	15.6
55 – 64	20.1	Student	6.3
65 or more	8.9	Retired	10.1
		Unable to work	31.1
Marital Status		Income	
Married	12.5	< \$25,000	21.7
Divorced	31.6	\$25,000 – \$34,999	15.6
Widowed	13.9	\$35,000 – \$49,999	6.3
Separated	28.6	\$50,000 – \$74,999	10.1
Never Married	22.9	> \$75,000	31.1
Unmarried Couple	33.6		
Education		Race/Ethnicity	
Less than High School	28.2	White, Non-Hispanic	20.8
High School Graduate/GED	23.4	Black, Non-Hispanic	26.5
Some College/Tech School	18.6	Other race, Non-Hispanic	17.5
College Graduate	7.3	Hispanic	13.0

Table 5: 2011 Arizona BRFSS, demographics of respondents who are current smokers

CDC Outcome Indicator 3.14.2. Prevalence of tobacco use during pregnancy

According to the Arizona Department of Health Services Bureau of Public Health Statistics (ADHS BPHS), Health Status and Vital Statistics Section the prevalence rate of women who report

tobacco use during pregnancy is 4.3 per 100 births in 2011, which is lower than 2005's report of 5.4 per 100 births.

ADULT PREVENTION: RESTRICTING EXPOSURE TO TOBACCO

Smoke-Free Arizona

Arizona went Smoke-Free in FY07. In November 2006, Arizona voters approved a statewide smoking ban (Smoke-Free Arizona Act A.R.S. §36-601.01), which essentially prohibits smoking in most enclosed public places, as well as worksites. The establishments are required to follow the 20 foot rule: smoking within 20 feet of an entrance is prohibited. According the Smoke Free Arizona website (www.smokefreearizona.com), the following establishments were required to implement the ban:

- Restaurants, bars, grocery stores, or any establishment that serves food
- Office buildings and work areas such as meeting rooms, employee lounges, classrooms, and private offices
- Healthcare facilities, hospitals, health care clinics, and doctor's offices
- Company-owned or employer-owned vehicles during working hours if the vehicle is occupied by more than one person
- Enclosed common areas in hotels and motels
- Lobbies, elevators, restrooms, reception areas, halls, stairways, and any other enclosed common-use areas in public and private buildings including condominiums and other multiple-unit residential facilities
- Any place of employment not exempted

There are some exempt public places, defined by A.R.S. § 36-601.01 (B), where smoking is allowed. The following is a list of exempt places:

- Private residences (except when used as a licensed child care, adult day care, or health care facility)
- Hotel and motel rooms designated as smoking rooms (no more than fifty percent of rooms rented to guests in a hotel or motel are so designated)
- Retail tobacco store (physically separated and independently ventilated so that smoke from retail tobacco stores does not infiltrate non-smoking areas)
- Veterans and fraternal clubs when they are not open to the general public
- Smoking when associated with religious ceremony practiced pursuant to the American Indian Religious Freedom Act of 1978
- Outdoor patios so long as tobacco smoke does not enter areas where smoking is prohibited through entrances, windows, ventilation systems, or other means
- Theatrical performance upon a stage or in the course of a film production or television production if the smoking is part of the performance of production
- Tribes are Sovereign Nations. The Smoke-Free Arizona Act has no application on Indian reservations as defined in A.R.S. §42-3301 (2).

The ADHS Office of Environmental Health is responsible for monitoring compliance with the law.

ADULT CESSATION: ARIZONA SMOKERS' HELPLINE (ASHLine)

ADHS BTCD funds the Arizona Smokers' Helpline (ASHLine), which offers free telephone coaching, free on-line quit coaching through WebQuit on www.ashline.org and free or reduced cost nicotine replacement therapies and other medications for smoking cessation. Starting FY09, BTCD no longer funded community-based cessation classes, and placed the statewide focus on ASHLine for cessation services. BTCD utilizes its tobacco funded partners to serve as referral development liaisons in metro and rural Arizona to promote ASHLine services.

The goal of ASHLine is to provide access to effective, research-based tobacco use cessation services for all Arizona residents. In order to achieve this goal, ASHLine offers the following services:

- Individual/personalized telephone counseling in English and Spanish
- Web-based information/online WebQuit
- Printed materials
- Access to free nicotine replacement therapies (NRT) and medications

Since its inception, ASHLine has received more than 10,000 calls each year and more than 12,000 referrals. ASHLine utilizes various approaches to maximize the accessibility of tobacco cessation, including:

- Individualized quit planning design
- Client anonymity and confidentiality
- Proactive counseling
- Structured protocol counseling
- Culturally competent and sensitive counseling
- Multilingual services, including English, Spanish, Korean, Arabic

ASHLine has a greater quit rate (nearly 40 percent) after six months compared to most national quitlines' quit rates (20 percent). When accompanied by medications ASHLine's quit rate is nearly 60 percent.

Medication to Assist Clients in Quitting

Current research indicates that one of the most effective tobacco cessation methods is a combination of quitline and nicotine replacement therapy, including prescription medications, otherwise known as Nicotine Replacement Therapies (NRT+). ADHS BTCD, during FY09 and FY10, offered a medication benefit to ASHLine clients older than age 18 who were enrolled in services. The distribution services ADHS BTCD contracted with for this service is beBetter Inc. The benefit included over-the-counter nicotine replacement therapy (NRT), specifically nicotine patches, gum, or lozenge. Clients are able to receive the benefit for two weeks. Unlike the voucher program, this program ships two weeks of products to the callers' homes. These efforts continued through FY11 and FY12.

Arizona Health Care Cost Containment System (AHCCCS) Title 19 beneficiaries can receive up to twelve weeks of the seven approved FDA nicotine replacement therapies (NRTs). Arizona has one of the most comprehensive and accessible benefits for NRTs to its Medicaid population.

While figures vary from state to state, Medicaid members typically constitute 10-40 percent of quitline callers seeking help in their attempts to quit using tobacco. In Arizona, Medicaid members who utilize the Arizona Smoker's Helpline (ASHLine) constitute 19% of ASHLine clients. State quitlines and tobacco control programs have a long history of partnership with state Medicaid agencies, primarily on three issues: 1) Expanding coverage (and decreasing barriers) for tobacco cessation services to Medicaid members; 2) Promoting existing cessation coverage and the availability of free quitline services Medicaid members; and 3) Gaining some level of funding and/or reimbursement for delivery of quitline services to Medicaid members. Arizona is currently partnering with AHCCCS to secure the CMS administrative match for Quitline Services. Securing this match is one step to ensuring sustainability of the ASHLine as well as providing quit tobacco services to underinsured populations

Users' Satisfaction with Tobacco Cessation Services

During FY09, the North American Quitline Consortium (NAQC) adopted an official formula for calculating the success of tobacco quitlines. ASHLine adopted the same formula to calculate its quit rate. For FY11 and FY12, the ASHLine quit rate was 32.3 percent and 33 percent respectively.

ASHLine Counter-Marketing

In 2010, ADHS BTCD launched a multi-faceted statewide media campaign titled "You Can Quit. We Can Help." to generate a greater call volume to the ASHLine and enrollment into ASHLine services. To achieve these goals, the primary objective was to generate between 525 and 720 calls per week. The second objective was to increase enrollment by at least 50 percent to approximately 830 enrollments per month. This campaign ran for eight months from May 2010 to November 2010.

Initially, ADHS BTCD utilized a campaign, titled "Dear Me," which was received free of cost from the State of Washington at the end of 2009. It was launched in the beginning of 2010, but it did not have a strong enough call to action to achieve ASHLine's goals; consequently, the "You Can Quit. We Can Help." Campaign was created to promote cessation services of ASHLine.

Prior to the media campaign initiated in January 2010, the primary way that clients heard about the ASHLine was through their healthcare providers. Fifty-eight percent of ASHLine clients indicated hearing about services through their doctor or at a healthcare facility. A description of the proactive Quitfax Referral program is detailed in the Healthcare Provider Services section.

Table 6: How ASHLine clients heard about services

	Pre-Campaign (%)	Campaign (%)
TV	2.0	42.5
Radio	0.8	2.0
Billboards/Other media	7.9	4.3
Friends and Family	9.0	5.8
Doctor/Healthcare Facility	58.1	32.3
All Other	22.1	13.1

The media campaign was based on the results of focus groups and various data sources (e.g. ATS, BRFSS, and reviews of cessation advertising best practices). Qualitative research showed that an average smoker knew smoking was bad for their health and had a strong desire to quit, but needed help. The data also indicated that a smoker on average makes an average of eight quit attempts before succeeding. The call to action was to get smokers to call ASHLine. The success of the campaigns is apparent in the change in the percent of clients who responded that they heard about ASHLine services on television. The proportion of clients indicating seeing ads on television rose from two percent prior to the media campaigns to more than 42 percent. See Table 2 for details.

Four commercials were created, and debuted in conjunction with an earned media (public relations) effort for the national recognition day— World No Tobacco Day— in May 2010. The campaign included the four new television commercials, existing radio commercials, in-theater commercials and earned media, which included a media “tour” of several counties in the state to visit print and radio stations for interviews. The four commercials ran in all mediums through the end of November 2010. An intense earned media push was done to coincide with a surge in the commercials airing for the Great American Smokeout on November 18, 2010. After the Great American Smokeout, the television commercials were discontinued until December 27, 2010. Re-launching with three new television commercials for New Years’ 2011, the campaign continued to see spikes in call volume resulting in calls exceeding 1500 calls per week for the first three weeks of the campaign. The campaign’s success was marked with continued spikes of 800, 900 and 1,100 calls per week during scheduled flight times of the media.

In May 2011 to coincide with World No Tobacco Day, the campaign launched three new commercials, new radio spots, outdoor billboards and digital web banners highlighting three former tobacco users who had all survived different forms of cancer. The commercials success was evident as continued calls spikes occurred throughout the summer as the ads were aired in targeted communities throughout Arizona.

Further development of the “You Can Quit. We Can Help.” campaign continued with the launch of seven new television commercials, radio spots, print ads and digital web banners on December 26, 2011. Seven individuals were selected to be featured in one commercial, and they were people who had used the ASHLine to quit tobacco. The range of demographics was highlighted as ethnicities, ages and professions varied greatly. They were a cross-representation of Arizonans statewide. The ads saw some success but not to the degree of the initial campaign ads. Calls from the same time the previous year were down 20-30 percent.

With the launch of the Centers for Disease Control and Prevention (CDC) ‘Tips from former smokers campaign’ in March 2012, ASHLine counter-marketing efforts were scaled back. This was done to prevent message confusion as there were multiple telephone numbers provided that linked directly to ASHLine.

Table 7: Budget for cessation marketing

Total Budget for Cessation Marketing	\$1,293,775
Expended for Dear Me media placements (television and radio)	\$700,745
Remaining for You Can Quit Campaign	\$593,030

You Can Quit. We Can Help. Campaign Budget	\$559,592
Television commercial production	\$48,433
Media placements (television)	\$362,561
Media placements (radio)	\$138,091
Media placements (print)	\$9,851
Print developed in-house/no hard cost	\$656

The Campaign reached both goals during the time period it ran in 2010. It helped to generate the greatest average monthly calls to ASHLine compared to all previous years combined. Data showed that ASHLine received more than 24,700 calls during the Campaign. The call volume during the Campaign exceeded the primary objective with 774 calls per week. The total call volume was 327 percent greater month for month over the prior year's call volume. Enrollment increased by more than 250 percent to 1400 enrollments per month, which exceeded the Campaign's second objective. In 2011, the campaign saw greater success receiving 37,300 and through June 30, 2012 received just over 15,000 calls. Enrollments remained at an all-time high with 12-month quits remaining steady at just under 40 percent.

Who are ASHLine Service Users?

The clientele of ASHLine is diverse, in part due to media reach. The following table (Table 8: ASHLine Client Demographics) is an indication of the clientele for FY11 and FY12. The percentages are based on the number of Client Intake Forms (CIFs) completed for the fiscal year.

Table 8: ASHLine client demographics

	Fiscal Year 2011 N(%)	Fiscal Year 2012 N(%)
Client Intake Forms Completed	17054 (100.0)	16067 (100.0)
Gender		
Male	6152 (42.3)	5182 (42.0)
Female	8387 (57.7)	7146 (58.0)
Service Language		
English	16201 (95.1)	14916 (93.4)
Spanish	825 (4.9)	1049 (6.6)
Sexual Orientation		
Heterosexual	12813 (96.2)	10496 (95.5)
Gay, Lesbian, Bisexual, or Transgender	500 (3.8)	498 (4.5)
Race		
American Indian/Alaska Native	173 (1.4)	169 (1.7)
Asian	61 (0.5)	61 (0.6)
Black or African American	872 (7.1)	827 (8.6)
Native Hawaiian or Other Pacific Islander	16 (0.1)	10 (0.1)
White/Caucasian	10107 (82.3)	8248 (83.0)
Other	1056 (8.6)	621 (6.4)
Hispanic		
Yes	2094 (16.2)	1828 (17.4)

No	10827 (83.8)	8658 (82.6)
Insurance		
AHCCCS	2818 (21.6)	2203 (19.4)
Other Insurance	6716 (51.5)	5881 (51.9)
None	3805 (29.2)	3246 (28.6)

Proactive Referral System/QuitFax

Health and human service providers are recommended to ask every client about their tobacco use at every visit. For those clients who are looking for help quitting tobacco, ASHLine has created a fax referral form (QuitFax) making it easier for providers to ensure clients have access to tobacco cessation services.

The ASHLine Referral Development Teams works with Arizona health systems to implement changes around policies and practice for assessing and treating tobacco use with every patient. During FY11, 93 health systems made more than 8,600 referrals to ASHLine; in FY12 103 health systems made more than 9,400 referrals (See Table 9.). The efforts of the Referral Development team reach beyond health systems when encouraging people to refer to ASHLine for tobacco cessation services. During FY11, 1,757 individuals at 769 locations made referrals to ASHLine. That number decreased to 1,704 individuals at 784 locations.

Table 9: Number of health systems referring to ASHLine

	FY11	FY12
# of Referring Systems	93	103
# of Referrals from the Systems	8610	9477

Table 10: Number of referring agents and locations

	FY11	FY12
# of Referring Agents	1757	1704
# of Referring Locations	769	784

Table 11: Number of referrals by location type

Location Type	FY11 # Referrals (%)	FY12 # Referrals (%)
Behavioral Health	1041 (9.4)	1529 (12.7)
BTCD Partner	1022 (9.2)	1672 (13.9)
Community Group	142 (1.3)	287 (2.4)
Community Health Center	1404 (12.7)	1290 (10.7)
Dental Practice	52 (0.5)	123 (1.0)
DOD/VA	75 (0.7)	51 (0.4)
Health Insurance Group	218 (2.0)	161 (1.3)
Hospital	2546 (23.0)	3128 (26.0)
IHS/Tribal 638	28 (0.3)	95 (0.8)
Medical Practice	3626 (32.8)	2706 (22.5)
Pharmacy	154 (1.4)	60 (0.5)
School/University	45 (0.4)	44 (0.4)

WIC	497 (4.5)	666 (5.5)
Worksite	214 (1.9)	224 (1.9)
Other	7 (0.1)	0 (0.0)
Total	11071 (100.0)	12036 (100.0)

Referrals may be made to ASHLine via a fax using the QuitFax form or online using ASHLine's online portal known as WebQuit. The form (both QuitFax and online) provides ASHLine with a client's name and contact information. Within 24 hours of receiving a referral, a referral call team member attempts to contact the client, with a minimum of three attempts to reach them in 10 days. The clients are informed of the telephone cessation coaching available at ASHLine. In order to keep the providers informed, ASHLine sends a fax or email with information on the services a client has accepted to the healthcare provider.

Table 12: QuitFax referral system

	Fiscal Year 2011	Fiscal Year 2012
	N (%)	N (%)
Total Referrals	11071	12036
Clients Enrolled	3434 (31.0)	4251 (35.3)
Received Some Level of Service (of the Clients Enrolled)	3058 (89.1)	3665 (86.2)

IDENTIFYING AND ELIMINATING TOBACCO-RELATED DISPARITIES

There are certain groups that exhibit disproportionately high morbidity and mortality rates associated with tobacco use. Factors including, but not limited to an individual's age, race/ethnicity, educational attainment, income, and sexual orientation, greatly contribute to health disparities within a given population. Tobacco-related disparities are demonstrated by increased prevalence of tobacco use, greater exposure to secondhand smoke, and limited access to educational information and prevention/cessation programming, among other considerations.

Starting in 2009 BTCDC contracted with eight community organizations to conduct community assessments that would assist with capacity building and program planning for the development of sustainable commercial tobacco prevention programs. The contracts with these community organizations are through September 30, 2013. BTCDC also wanted to engage community partners to achieve sustainable positive change in reducing health disparities relating to diabetes, tobacco-use, and obesity.

With the combined resources of tobacco tax revenue dollars and CDC grant funds, eight community organizations, including eight sub-contracts, six of which were funded to conduct community and health systems assessments with the end goal of increasing utilization of services. The funded organizations will be conducting work in various communities throughout the state in these population groups:

- African American
- American Indian: seven tribal nations and three urban centers
- Asian-Pacific Islanders

- Hispanic youth and families
- Lesbian, Gay, Bisexual and Transgender
- Migrant farm workers
- Re-entry jail population

A number of assessment methods were utilized for the community assessments. These methods included: asset mapping, surveys, focus groups, key informant interviews, and best practice reviews. BTCD worked with the organizations in the development of the questions used in the surveys, focus groups, and interviews. Throughout the process, BTCD assisted with survey data analysis, training on report writing, and facilitation of strategic planning. The following is a summary of the results from each of the community assessments.

Black Hills Center for American Indian Health (BHCAIH): Navajo Nation Project

The strategic plan outlined by BHCAIH for fiscal year 2011 is to work with hospitals/clinics to:

- ask patients about tobacco use
- refer smokers to quit lines

BHCAIH collaborates and participates in the “Honoring the Spirit” (HTS) Coalition. Through the HTS coalition BHCAIH advocates for tobacco cessation policy implementation which includes staff training and patient screening into their electronic health records, and cessation referral to either ASHLine or a traditional healer. BHCAIH identified three tribal health service units for this endeavor. All three of the service units were in the process of upgrading their electronic medical records. One service unit had created a tobacco screening policy, which included the 5A and R protocol for their providers, and were waiting for approval from the tribal health board to approve. The other two service units were in the process of creating policy and protocols.

BHCAIH has also worked with the Traditional Medicine Group within the HTS Coalition to increase the traditional healer’s roles within tobacco control and policy. The coalition efforts have resulted in several traditional healers establishing voluntary policies of “no use of commercial tobacco” during ceremonies.

BHCAIH also worked closely with Navajo Nation President Ben Shelly and his administration to pass an Executive Order that would prohibit the use of commercial products in all public places and workplaces within the Navajo Nation. Unfortunately the order was nullified by the Navajo Nation Attorney General, but the process has brought more attention to the need for tribal legislation regarding smoke free facilities.

BHCAIH determined that based on the new direction that the CDC was taking for the CHIRD funding that they would not be able to continue contracting with BTCD for services. Fiscal year 2011 was the last year that BHCAIH received funding from BTCD. BHCAIH was able to apply for other funding to continue their work with the HTS Coalition, and BTCD and its county contractor will continue to collaborate with BHCAIH.

Asian Pacific Community in Action: Asian Pacific Islanders

During fiscal year 2011 and 2012 worked with BTCD to put in place an agreement with the UC Davis California Quitline to refer AAPI clients to their quitline services. The California Quitline

has the capacity to provide services in many AAPI languages, which the ASHLine is unable to provide at this time. APCA reached out to several healthcare providers who work with the AAPI community to inform them of the new service and to educate them on how to refer clients for services.

APCA is also a participating member of the newly formed AZ Smoke Free Living Coalition. Through the coalition a tobacco survey of person(s) living in multi-unit housing were completed and the coalition is working to promoting multi-unit smoke free housing policies to those interested in Maricopa County. APCA has reached out to several managers' of multi-housing complexes where members from AAPI community reside to discuss this initiative.

APCA provides workshops based on the Stanford – Chronic Disease Self-Management (CDSMP) Curriculum. They have successfully recruited and trained several Master Trainers who in turn train members of the community to become lay leaders who provide the workshops. Due to this endeavor they have held several workshops in the AAPI community. They have also worked with several providers in the area to educate them about the availability of the workshops and worked out a referral system for CDSMP workshops.

Prescott Pride Center: Lesbian, Gay, Bisexual, and Transgender Community

In fiscal year 2011 and 2012 Prescott Pride Center educated staff on the 2A's and R brief tobacco intervention and also how to referral for ASHLine services. Throughout the year PPC did ASHLine referral outreach to several local providers who worked with the LGBT community to provide education on doing brief tobacco interventions and referral for ASHLine services, they also worked with a local agency that works with the homeless to do ASHLine referrals.

PPC collaborated with the Yavapai Tobacco-Free Partnership to become trained in the Stanford model for Chronic Disease Self- Management curriculum. Through their efforts they are able to co-facilitate workshops to ensure that the LGBT community has a workshop facilitator who is culturally appropriate for members of their community.

PPC discontinued funding after fiscal year 2012 due to the disbanding of the center.

Worthy Institute: Hispanic Youth

The strategic plan for Worthy Institute Fiscal Year 2010-2011 was to assist in the recruitment and development of the Join the Movement Statewide Youth Coalition effort, as well working with community groups to provide education and referral information for tobacco cessation and other health related needs.

WI acted as the agency to receive registration for the "The Movement". WI identified youth leaders from those registering with and organized conference calls, provided education on leadership training and skills, and assisted with organizing statewide events. WI organized flash mobs for Kick Butts Day and World No Tobacco Day to showcase youth fight against tobacco. The Youth Tobacco Community Assessment Project's aim is to strengthen the health infrastructure that address tobacco related issues facing Hispanic youth and their families.

While developing a strategic plan, the project identified and developed partnerships and other groups to collect data and identify appropriate resources within the impacted community.

Due to change in direction for funding activities Worthy Institute no longer received funding after fiscal year 2010-2011.

Inter Tribal Council of Arizona, Inc. (ITCA): Five Tribal Nations and Three Urban Centers

Based on these community assessment findings, the Tribes and the Urban Centers (UC) developed a Strategic Plan that would:

- Integrate tobacco prevention with chronic diseases programs
- Implement a reminder system among health providers of tobacco products
- Work with youth, coalitions, and existing networks to implement strategic plan

ITCA and their subcontractors provided education on the 2A's and R brief tobacco intervention and education on referring to ASHLine within their tribal system or UC. They worked with staff to revise intake forms to screen for commercial tobacco use and offer referral for cessation services. Some of the programs which revised forms were diabetes programs, WIC, Cancer Programs, Head Start Programs, Senior Programs, behavior health programs, and other social and technical training programs. One tribe was able to incorporate the ASHLine referral form into their electronic health record. Tribal programs and UC also reached out to their local IHS service providers to provide education and training for referral for commercial tobacco usage.

Tribes and UC work with youth within their communities to provide guidance and assistance in organizing local native youth coalitions. These coalitions participated in the "Join the Movement" Coalition effort, which morphed into the STAND Coalition. Youth in these communities participate in both community and statewide commercial tobacco prevention efforts like Kick Butts Day, World No Tobacco Day, and regional coalition trainings, and the statewide STAND summer conference. Native American youth provide education on the difference between traditional and commercial tobacco as well as advocating for commercial smoke free policies within their communities.

Concilio Latino de Salud: Re-Entry Jail Population (Maricopa County)

CLDS strategic goals for fiscal year 2011 are to assist the incarcerated person reentering a community into becoming tobacco free:

- Provide outreach in the Maricopa County Jail system prior to person reentry into the community.
- Provide tobacco education and training to organizations that provide services in the I-17 Canyon Corridor.
- Provide tobacco education ASHLine information to community volunteers in the I-17 Canyon Corridor.

CLDS received approval from the Maricopa County Jail Commander to hold information sessions for incarcerated persons who were preparing for release. They provided inmates with pamphlets and information regarding the Arizona Health Care Cost Containment System

(AHCCCS) application process, which is the state Medicare/Medicaid run system; and ASHLine services. Concilio Latino de Salud initially wanted to reach out to the reentry population at the county probation offices; the probation office informed Concilio Latino de Salud that due to budgeting constraints that office space was not available. CLDS offered office space at the Community Life Center, where they met with the reentry population to assist them with processing their AHCCCS applications and to screen for tobacco use and offer tobacco education and referral for ASHLine services.

The CEO of CLDS became a member of the Canyon Corridor Weed and Seed Coalition. She was elected the chairperson for Prevention, Intervention, and Treatment Committee. Through this coalition CLDS was able to collaborate and network with various groups working with the prison reentry population in the area.

CLDS trained all their staff on the risks and harm of tobacco and the ASHLine referral process. They also provided tobacco education and ASHLine referral training to other organizations that worked with the prison reentry population.

CLDS determined that based on the new direction that the CDC was taking for the CHIRD funding that they would not be able to continue contracting with BTCD for services. Fiscal year 2011 was the last year that CLDS received funding from BTCD. CLDS continued to work with the Canyon Corridor Weed and Seed Coalition on processing applications for AHCCCS and other services.

Campesinos Sin Fronteras (CSF): Hispanic and Migrant Farmworkers

Staff collaborated with various faith groups to provide training and education on chronic disease prevention and tobacco prevention. Each faith based group identified a member to be trained to provide education and information to their members. CSF utilized the “Tu Corazon, Tu Vida” curricula for disease prevention and the two A’s and R for brief tobacco intervention. They also trained various community service agencies on the brief tobacco intervention and how to refer to ASHLine for tobacco cessation services.

CSF staff received approval from four agricultural companies to provide chronic disease prevention and tobacco prevention education to workers. They did this during the early morning prior to workers being transported to work, their break times, and during health fairs that were held in the fields. Many workers received information and referrals for services ranging from tobacco cessation, chronic disease management, dental services, mental health services, domestic violence services, cancer support referrals, and information on how to obtain free or reduced cost health screenings.

CSF worked to recruit youth for the “Join the Movement” which morphed into STAND, the statewide youth coalition. CSF have assisted youth in organizing and developing their community youth coalition and youth participate in statewide activities like Kick Butts Day, World No Tobacco Day, and regional youth trainings, attending statewide conferences, as well as working within their community towards tobacco policies and to promote tobacco prevention.

CSF is surveying individuals to gauge their interest and feelings on smoke free housing. They are also working with apartment complex management and housing authority to education those on smoke free housing and how to implement smoke free housing.

Tanner Community Development Corporation: African American

Tanner Community Development Corporation faith based youth groups continues to have strong support and interest in the statewide youth coalition called STAND. Youth from several churches participated in youth groups who received training in public speaking and leadership skills giving them the ability to talk to their peers and members of their community regarding tobacco issues. TCDC youth groups participate in regional youth trainings as well as participate in the planning conference and the Summer Conference. They are currently looking to developing an initiative around a smoke free park within one of their communities.

TCDC is also a participating member of the newly formed AZ Smoke Free Living Coalition. Through the coalition a tobacco survey of person(s) living in multi-unit housing were completed and the coalition is working to promoting multi-unit smoke free housing policies to those interested in Maricopa County. TCDC has worked with several multi-unit housing complexes to become either smoke free or having a designated smoking area.

TCDC is highly invested in the Stanford Chronic Disease Self- Management curriculum. Since the inception of this endeavor TCDC has worked with 10 churches to identify leaders to act as advocates for this initiative. They have trained several lay leaders who provide the CDSMP workshops within the faith community. Also through this initiative they were able to assist eight churches to become “Smoke Free” Campuses and several other developed designated smoking areas.

TCDC also worked to train their community groups and partners on the 2A’s and a R for brief tobacco intervention as well as the referring to ASHLine for cessation services.

Integration of Tobacco and Chronic Disease Services - Community Health System

In 2011 BTCD solicited a Request for Grant Application (RFGA) for the “Integration of Tobacco and Chronic Disease Services”. The purpose of the grant was to improve the health status of people by supporting communities to coordinate and integrate services to build a community health system that will support the utilization of tobacco-cessation, cancer, cardiovascular disease/stroke, pulmonary disease, and diabetes services.

The grant funded project is to focus on communities in one of five counties in Arizona: Gila, Graham, La Paz, Mohave, and Navajo. These counties were chosen based on their rankings on health outcomes (mortality and morbidity) and health factors (health behaviors, clinical care, social and economic, physical environments) according to the report, County Health Rankings – Mobilizing Action Toward Community Health, prepared by the Robert Wood Johnson Foundation and University of Wisconsin. (<http://www.countyhealthrankings.org/arizona>). The Grant requires the use of funds for the integration of services that improve their effectiveness. Examples of integration:

- Development of interagency coordination mechanisms and partnerships with community partners for increased/improved service delivery (e.g. building provider networks, building functional and sustainable linkages among service partners);
- Development of procedural processes to support needed collaborative service systems improvement (e.g. change in standards of practice, data sharing);
- Training/workforce development to assist staff or other providers in the community provide effective services consistent with the purpose of the grant program; and
- Redesigning processes, as needed, to enhance effectiveness, efficiency and optimal collaboration between service providers.

La Paz Regional Hospital (LPRH): Community Health System

LPRH completed a community needs assessment in collaboration with the La Paz County Health Department to recruit potential partner's for a coalition of healthcare agencies and other organizations to address the tobacco and chronic disease needs within the county. The coalition created a vision/mission statement, discussed interventions, and referral systems. The coalition branded their group the "La Paz County Tobacco Chronic Disease Network". The network reviewed and discussed the results from the community needs assessment and developed a strategic plan based on the outcomes; they also created a referral pamphlet called the "La Paz County Healthcare Resource Guide" to be distributed to area providers and patients; and a program evaluation plan. Based on the strategic plan and the evaluation plan the groups will focus on education and intervention with measurement and evaluation based on the number of referrals to ASHLine and the county Healthy Living Workshops.

LPRH assessed their internal systems for both inpatient and clinic services to determine appropriate levels of screening for tobacco use and chronic disease management, as well as to identify possible improvements. LPRH reviewed registration and discharge protocols with the nursing departments to determine when and where appropriate screening and education could be initiated with patients. Forms were created to educate patients about tobacco cessation and risk factors and chronic disease education upon registration or discharge. Referrals forms have been created for both inpatient and clinic providers to refer patients for services. LPRH staff also received training from ASHLine on the ASHLine referral process and how to do an online proactive referral. LPRH staff worked to incorporate screening tools into their electronic medical record system. The system requires staff to screen for tobacco use and chronic disease prior to moving to the next field, this was done to ensure better compliance and initial review of charts indicate 88% - 100% compliance in all areas. LPRH continues to work on improving processes and creating a tracking mechanism for intervention and education improvement.

LPRH and associated clinics notified staff and the community that they would become tobacco free campuses effective January 1, 2011. Preparations included articles in the hospital newsletter which were available to all hospital staff and county residents, permanent signage posted on grounds, posters, brochures and education regarding the campuses tobacco free status. Employees and patients/visitors were offered referrals to ASHLine for quit services or medication.

REDUCING THE BURDEN OF CHRONIC DISEASE

In 2010, chronic disease – including cancer, heart disease, chronic lower respiratory disease, Alzheimer’s disease, diabetes, and chronic liver disease & cirrhosis were responsible for seven of the ten leading underlying causes of death in Arizona. When combined, these chronic diseases were responsible for more than 29,500 Arizona deaths in 2010. (Arizona Health Status & Vital Statistics, 2010).

In addition to 9,719 deaths that had heart disease assigned as the underlying cause, another 6,789 deaths had diseases of the heart assigned as the other than underlying cause. The sum of these two counts (16,508) is the total number of deaths that had any mention of diseases of the heart on the 2010 death certificates.

In 2010, diseases of the heart were the leading cause of death for American Indians. Cancer was the number one cause of death for Asians or Pacific Islanders, Blacks or African Americans, Hispanic or Latinos, and White non-Hispanics.

These leading causes of mortality and morbidity share common primary risk factors, including obesity, commercial tobacco use, poor nutrition and physical inactivity. However, their relationship is not limited to common indicators. Quite often, the populations most burdened by these conditions overlap; diabetes, for example, is also a significant risk factor for cardiovascular disease (CVD).

When looking at burden of chronic disease in Arizona, the following can be found:

- In 2009 heart disease was the first leading and cancer was the second leading cause of death in Arizona. However in 2010, cancer was the leading cause of death (22.7% of all deaths), followed by heart disease (21.2% of all deaths). When combined, cancer and diseases of the heart were the underlying cause of 43.9% of all Arizona deaths in 2010.
- In 2008, 7.8% of Arizona adults had been told by a doctor that they have diabetes. In 2009 this percentage increased to 8.4% and in 2010 to 9.0% (CDC – BRFSS). When accounting that a third of the population with diabetes is undiagnosed, it is not unreasonable that there are nearly 600,000 adults with diabetes in Arizona. (Arizona Diabetes Burden Report – 2011)
- Nearly 1.2 million people in Arizona are obese, 477,649 more people than 10 years ago. Arizona is tenth in the nation for obesity.

American Lung Association

Through a contract with the American Lung Association (ALA), ADHS-BTCD is increasing provider education and system development for screening for COPD. Specifically, ALA will be educating the public, people living with COPD, healthcare community, and decision makers about risks for chronic lung disease, relevant resources, and build awareness of indoor air quality issues through a social media campaign, collateral material and website. They will also be collecting surveillance data to determine the impact of indoor quality as it affects COPD and other chronic respiratory conditions in Arizona. ALA will provide a statewide forum for individuals living with lung disease, medical professionals, members of the healthcare industry and community agencies invested in respiratory issues to convene and will build relationships with decision makers in the multi-unit housing community to assist them in creating smoke-free policies in communities throughout Maricopa County.

Breast and Cervical Cancer Early Detection Program/Well Woman HealthCheck Program

Eligibility for Arizona's Medicaid Program, AHCCCS, changed in 2011. Childless adults, usually someone 45 or older, were no longer eligible for AHCCCS. Women in this category began looking for other avenues through which they could receive their annual screenings. WWHP staff noticed an increase in volume. During fiscal year 2012, July 1, 2011 to June 30, 2012, contractors had used up their screening and diagnostics budget by February. It appeared that screening would have to stop in February. The Bureau of Tobacco and Chronic Disease (BTCD) provided \$300,000 in Tobacco Tax Revenue to support screening and diagnostics through the end of the program year. This allowed an additional 1,546 women to be screened.

Please see Charts 1 and 2 below to view program volume over time.

Chart 1

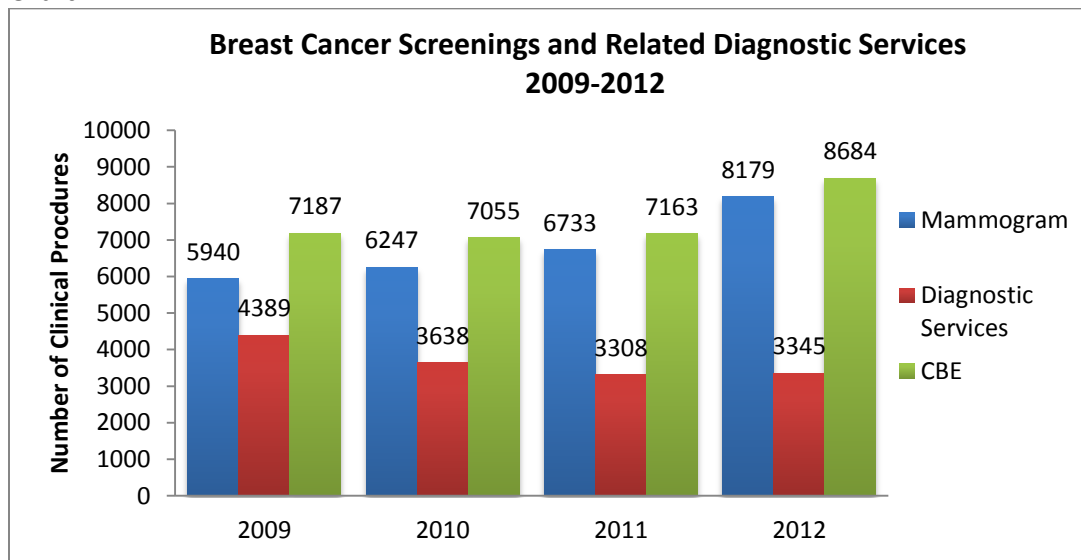
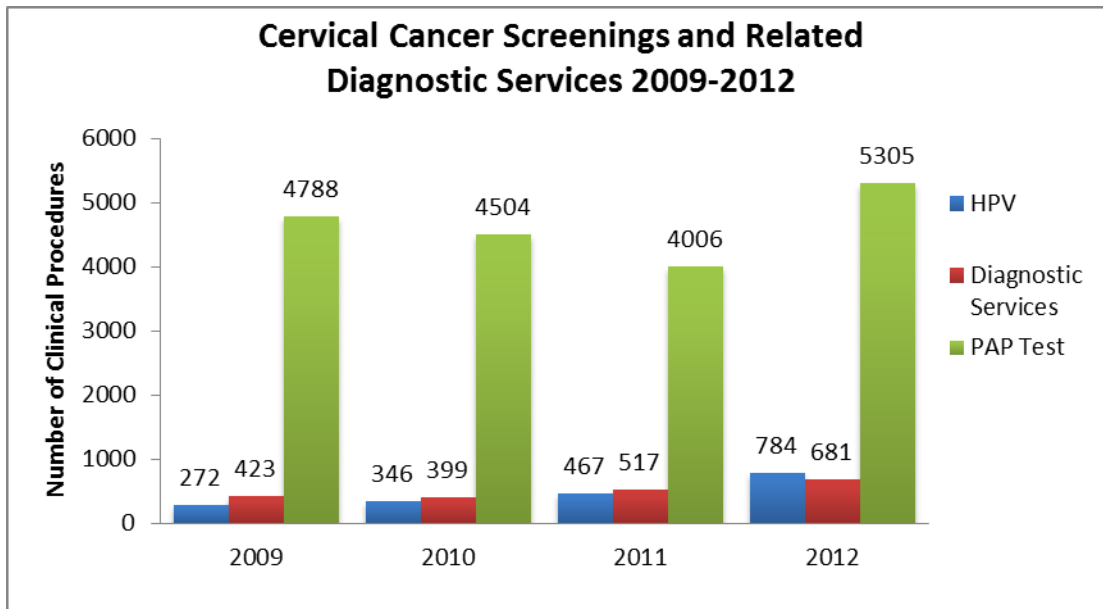
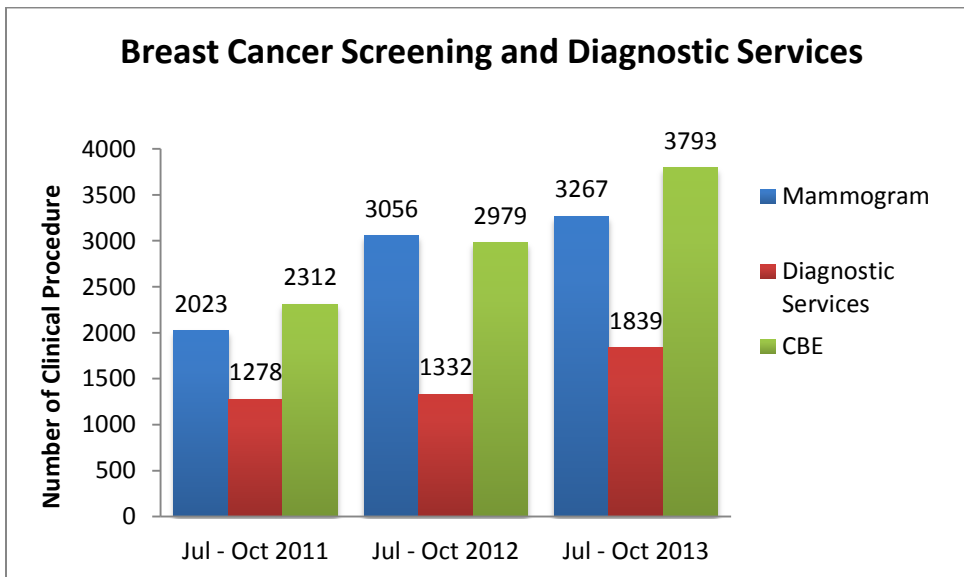


Chart 2



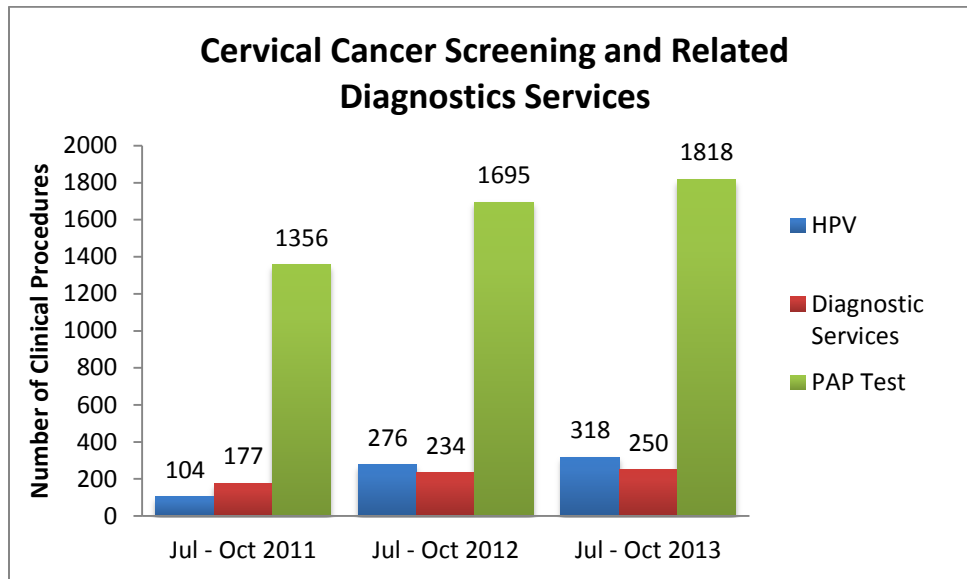
During fiscal year 2013 the volume increase has continued. The volume shift has been analyzed and can be seen in Charts 3 and 4 below.

Chart 3



Note: The impact of the change in Medicaid eligibility can be seen beginning in fiscal year 2012.

Chart 4



Note: The impact of the change in Medicaid eligibility can be seen beginning in fiscal year 2012.

The volume of services provided has increased and this has led to an increase in the volume of data to be entered into the CDC data system by program staff. At this time, data is entered through October 2013; this is why Charts 3 and 4 compare the data for the first four months of each fiscal year. The number of mammograms provided in the first four months of program year 2013 increased by 1,244 or 61% over program year 2011. Number of CBE's provided increased by 64%. The number of pap smears provided in the same time frame increased by 34%. The clinical algorithms for pap smears have changed to screening every three or five years. Increases will not be seen as quickly in this area of cancer screening.

The increase in volume is substantial and has continued. The Bureau of Tobacco and Chronic Disease (BTCD) was contacted regarding the lack of funds for ongoing screening in fiscal year 2013. BTCD was able to provide \$100,000 (Tobacco Tax Revenues) to support ongoing screening. Those funds have been distributed to the WWHP contractors. Most contractors expect to run out of screening funds by March 2013. Maricopa does not have the funds to continue screening and will focus on concluding the diagnostics required for the women already screened.

Chronic Disease Self Management Program (CDSMP)

Self-management programs provide individuals with education and tools they need to help them cope with chronic diseases such as diabetes, heart disease, lung disease, or arthritis. The programs help participants manage stress, discuss the benefits of physical activity and good nutrition, and help participants communicate more effectively with health care providers. Participants develop action plans related to these topics through structured planning and feedback exercises. The Stanford University Chronic Disease Self-Management Program (CDSMP), which serves as a model for this initiative, teaches consumers skills to manage their conditions and build their self-confidence so they can be successful in adopting healthy

behaviors, improve communications with their physician, and enhance their quality of life. The program consists of workshops conducted once a week for two and a half hours over six weeks in community-based settings such as senior centers, congregate meal programs, faith-based organizations, libraries, YMCAs, YWCAs, and senior housing programs. People with different chronic health conditions attend together, and the workshops are facilitated by trained and certified leaders, at least one of whom usually has a chronic illness.

BTCD currently contract with two entities to coordinate the implementation, reporting and fidelity of state and federally funded Chronic Disease Self-Management Programs in Arizona. These two entities are the Arizona Living Well Institute, a program of Empowerment Systems Inc., and Yavapai County Public Health Department.

Colorectal Cancer Prevention & Early Detection/ Fit at Fifty HealthCheck Program

The goal of this program is to increase colorectal cancer (CRC) screening rates for Arizonans through implementation of population based practices focused on systems change and the use of evidence based strategies. The program pays for CRC screening services and case management/patient navigation for the uninsured and patient navigation for the insured. Until December of 2012 funding was provided by CDC and Tobacco Tax Revenues. The Tobacco Tax Revenues were provided via collaboration with the Bureau of Tobacco and Chronic Disease. Tobacco Tax Revenues were used to provide services for symptomatic patients, as these services cannot be provided with CDC funds. In addition, CDC has limited the amount of their funding allowed for service provision to 20%. The remaining funds (80% of CDC funds) are used to support patient navigation and systems change.

Screening tests used are immunochemical fecal occult blood test (iFOBT), and colonoscopy. Nineteen colorectal cancers have been diagnosed and 522 adenomatous polyps have been removed. (Adenomatous polyps are considered CRC precursors.) Screening baselines at contracted federally qualified community health centers (FQHCs) have increased across the board. Those clinics addressing clinic colorectal cancer screening policy up front have been more successful improving the clinic screening rates. For example, between January and October 2012, El Rio raised their screening baseline from 38% to 45%. El Rio took the step to implement standing orders for CRC screening for all patients 50 and older.

FFHP had expanded and is now contracting. Without the Tobacco Tax Revenues, community health centers have had to reduce the number of patient navigators for the program. They are unable to screen symptomatic patients. Mountain Park is now providing the services at two sites instead of five. This type of change is occurring for all contractors.

CDC has built the Colorectal Cancer Control Program as a screening program that monitors and drives the quality improvement of colorectal cancer screening across the United States. FFHP is not a program that simply provides screening; it also is responsible for improving timeliness and quality of the screenings provided. CDC reviews 100% of the services provided, those services are then compared to the quality guidelines and a program specific report card is produced. Please see the Core Quality Indicator Summary for the FFHP's most recent results.

Table 13: Core Quality Indicator Summary FFHP

INDICATOR TYPE	DESCRIPTION	CDC BENCHMARK	ARIZONA
Screening Priority Population	Percent of new clients screened who are at average risk for CRC	≥ 75%	92.2%
	Percent of average risk new clients screened who are aged 50 years and over	≥ 95%	100%
Completeness of Clinical Follow-up	Percent of abnormal test results with diagnostic follow-up completed	≥ 90%	95.7%
	Percent of diagnosed cancers with treatment initiated	≥ 90%	100%
Timeliness of Clinical Follow-up	Percent of positive tests (FIT) followed-up with colonoscopy within 90 days	≥ 80%	98%
	Percent of cancers diagnosed with treatment initiated within 60 days	≥ 80%	100%

CPR Dispatch Initiative

Heart-related deaths are the leading cause of mortality in the United States.¹ An estimated 383,000 annual out-of-hospital cardiac arrests (OHCAs) make OHCA a major public health problem.² While most occur in adults, OHCA can strike all ages and is a significant problem in children. It results in death in all but 7.6% of cases nationally,³ but a 500% regional variation in survival suggest that system factors have a profound impact on outcomes.¹

The Bureau of Tobacco and Chronic Disease is currently funding a statewide public health initiative to improve care and evaluate outcomes for OHCA has resulted in a quadrupling of neurologically-intact survival. This program is called the Arizona TARGET (Telephone-Assisted Resuscitation Gains Essential Time) Program initiative. The goal of this program is to increase OHCA survival with positive neurologic outcome by improving the provision of pre-arrival CPR instructions and elevating rates of Bystander CPR, the essential bridge that buys time for EMTs racing to the scene with an AED. To this end, the program plans to provide 9-1-1 centers across the state with the protocols, training and quality-improvement tools recommended in the American Heart Association's latest Guidelines for telephone-assisted CPR.

Get with the Guidelines

The ADHS Office of Chronic Disease is funding a quality improvement program which improves the delivery of stroke care in Arizona hospitals. The American Heart Association Get with the Guidelines (GWTG) program is an evidence-based quality improvement program which utilizes a patient management tool to improve the quality of care, per CDC guidelines, for stroke patients. Stroke is the 4th leading cause of chronic disease death in Arizona and the leading cause of long-term disability. Through the GWTG quality improvement program, hospitals in Arizona will improve delivery of stroke care, thus reducing death and long-term disability.

Health in Arizona Policy Initiative (HAPI)

In January 2012, it became clear that in order to achieve the goals of coordinated chronic disease; a true “health in all policy” approach was needed. As a result, ADHS created the Health in Arizona Policy Initiative (HAPI). HAPI is a Public Health Services Division collaboration which leverages State funding (tobacco tax and lottery) with Federal (Title V – Children and Youth with Special Health Care Needs) to address social determinants of health through a “health in all policies” approach within worksites, communities, schools and health systems. The goal of HAPI is to provide infrastructure and implementation funding local county health offices that choose to participate in the initiative. Program staff and leadership from ADHS, including the Office of Chronic Disease, will provide technical assistance to the HAPI contractors on implementing policy, system and environmental (PSE) change. HAPI is built upon the leveraging of resources, development of relationships, and engagement of all populations on advancing efforts which make the healthy choice the easy choice for populations.

Worksite Wellness Initiative

Funding has been made available to assist employers in Arizona on the development and implementation of evidence-based worksite wellness programs. Comprehensive worksite wellness programs are proven to not only help organizations control healthcare costs, including those associated with chronic conditions such as heart disease, diabetes, and pulmonary disease, but they also increase productivity amongst employees. Many employers however do not have an understanding of how to implement such a worksite wellness program, often neglecting the connection between prevention initiatives and health plan benefit design and utilization. ADHS contracts with the Maricopa County Department of Public Health, the Arizona Small Business Association, and Viridian Health Management to assist employers successfully implement evidence-based healthy worksite initiatives to improve the health of their employees and businesses.

MUCH ACCOMPLISHED...AND MUCH MORE TO DO!

Just two years ago, I reported in the Biennial Report that we had worked with our many partners at the local, state and national levels to launch the beginning of a major change in the prevention and treatment of tobacco use and chronic disease! We had implemented new program directions that were characterized as “evidence-based,” more sustainable at the local and state levels, and able to withstand an era of decreasing revenues. Since then, during the past two years, *Arizona has moved the bar on several important areas of tobacco control, and is ranked in the “Top Ten” of several major categories:* lowest exposure to secondhand smoke in the home and workplace, lowest tobacco use among pregnant women, highest drop in overall tobacco use, highest drop in heavy tobacco use among youth, fifth lowest tobacco use among women, and seventh lowest overall tobacco use.

Through robust efforts in creating a state-of-the-art Quitline, establishing linkages to healthcare systems, increasing public awareness and skills in quitting tobacco, using social media and the internet to reach youth, enforcing laws pertaining to tobacco sales to youth, and building the beginnings of a statewide youth movement, *fewer Arizonans are now using tobacco and the implications for a healthier, less costly Arizona are clearly evident.*

But, while we have accomplished a great deal, we still have more to do. Tobacco use is on the rise among 12th graders in our state, and many of our youth are turning to hookah and smokeless tobacco, and we must continue our vigilance on the dangers of addiction. And while tens of thousands of Arizonans have quit smoking, more than 800,000 continue to smoke and endanger children with second-hand, and even third-hand smoke. Thus, we must continue to ensure high levels of evidence-based strategies such as bold social marketing, data-proven quitlines, and access to medications for those who are uninsured or under-insured.

In the U.S, seven out of ten deaths each year are the result of chronic diseases that could have been prevented or effectively managed. Heart disease, cancer, lung disease and stroke account for more than 50 percent of all deaths each year. Through new and expanded community partnerships, we are identifying and reducing health disparities and helping people living in rural areas gain access to stroke treatment.

By merging the Bureaus of Tobacco and Chronic Disease, we have brought integration and efficiencies that can ease the burden of chronic disease in Arizona, as more people seek annual health checks, know their blood pressure, cholesterol and glucose levels, and acquire the necessary self-management skills that can extend their years of life and productivity.

Working side-by-side with our many partners across Arizona, every day we move closer to our goal of having a state that is free of commercial tobacco abuse; every day we gain ground in the fight to reduce unnecessary suffering and loss due to preventable disease; and every day we increase the financial gain that benefits us all when people choose healthy behaviors.

Wayne Tormala, Bureau Chief
Bureau of Tobacco Education and Prevention
Arizona Department of Health Services
February 2013